

# P-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Apr/14/2014

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right diagnostic shoulder arthroscopy (DSA), subacromial decompression, rotator cuff repair, extensive debridement, synovectomy

### A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Orthopedic Surgery

### REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

#### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury to his right shoulder when he was falling on xx/xx/xx. The clinical note dated 02/14/14 indicates the patient complaining of right shoulder pain. The patient stated that specific movements do intensify the pain within the shoulder to include reaching upward and lifting objects. Upon exam, the patient was able to demonstrate 120 degrees of right shoulder flexion and 45 degrees of abduction. The therapy note dated 02/19/14 indicates the patient having initiated physical therapy for the right shoulder complaints. The clinical note dated 02/24/14 indicates the patient continuing with right shoulder range of motion deficits. The patient had a positive impingement sign. Moderate tenderness was identified upon palpation at the anterior region of the right shoulder. The MRI of the right shoulder dated 02/28/14 revealed a small partial tear of the distal supraspinatus tendon. Mild subscapularis tendinosis was also identified. Minimal subacromial and subdeltoid bursal fluid was also revealed. The clinical note dated 03/05/14 indicates the patient continuing with right shoulder symptoms. The pain was located at the anterior aspect of the shoulder. The clinical note dated 03/07/14 indicates the patient utilizing Percocet, Norco, and Celebrex for pain relief.

The utilization reviews dated 03/14/14 & 03/20/14 resulted in denials as no information was submitted regarding the patient's completion of a full course of physical therapy addressing

the right shoulder complaints.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The documentation indicates the patient complaining of right shoulder pain with associated range of motion deficits. An arthroscopic subacromial decompression with a rotator cuff repair, extensive debridement, and synovectomy would be indicated provided the patient meets specific criteria to include completion of all conservative treatments. It appears the patient has initiated physical therapy to address the right shoulder complaints. However, no information was submitted regarding the patient's completion of all conservative treatments to include a 3 month course of physical therapy as well as injections. Given this, a surgical intervention would be premature at this time. Therefore, this request is not indicated. As such, it is the opinion of this reviewer that the request for a right shoulder arthroscopic subacromial decompression, rotator cuff repair with extensive debridement, and synovectomy is not recommended as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)