

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Apr/02/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** left shoulder diagnostic arthroscopy/SAD/rotator cuff repair/synovectomy/treatment as indicated proximal bicep tenotomy/tenodesis/extensive debridement

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., 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.** It is the opinion of this reviewer that the requested left shoulder diagnostic arthroscopy/SAD/rotator cuff repair/synovectomy/treatment as indicated proximal bicep tenotomy/tenodesis/extensive debridement is not recommended as medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury to his left shoulder. The clinical note dated 12/03/13 reports the patient complaining of left shoulder pain. The patient stated that on xx/xx/xx, he felt a pop in his left shoulder. The patient reported severe pain immediately thereafter. The patient's past medical history is significant for a rotator cuff repair on the right. However, no date was provided. The patient rated the pain as 6/10. Raising the arm overhead exacerbates the pain. Decreased range of motion was noted with internal rotation. Moderate tenderness was identified at the supraspinatus, trapezius, and rhomboids. The MRI of the left shoulder dated 12/16/13 revealed tendinopathy at the supraspinatus, infraspinatus, and subscapularis with no tear. Moderate osteoarthritis was revealed at the AC joint. Mild subacromial subdeltoid bursitis was identified. No labral tear was revealed. The therapy note dated 01/31/14 reports the patient having completed 7 physical therapy sessions to date. The clinical note dated 02/05/14 indicates the patient continuing with 5/10 pain at the left shoulder. The note indicates the patient utilizing Celebrex for pain relief.

The clinical note dated 02/10/14 reports the patient continuing with left shoulder pain. Upon exam, tenderness was identified at the anterior portion of the shoulder joint. The patient was able to demonstrate good range of motion. The patient had a positive Speed's and O'Brien's test. The clinical note dated 02/24/14 indicates the patient continuing with left shoulder weakness, with a popping, clicking, and locking. The patient was utilizing Norco, Celebrex, and Percocet for pain relief. Strength deficits were identified with abduction, flexion, and internal rotation.

The utilization review dated 02/17/14 resulted in a denial for a surgical intervention at the left shoulder as no record of the patient having completed a 3-6 month course of conservative care was submitted. No information was submitted regarding the patient's specific complaints of pain with active range of motion from 90 to 130 degrees.

The utilization review dated 03/04/14 resulted in a denial as no imaging studies were submitted confirming the patient's rotator cuff tear.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The documentation indicates the patient complaining of left shoulder pain with associated range of motion deficits. A rotator cuff repair, subacromial decompression, synovectomy, biceps tenotomy, and tenodesis would be indicated provided the patient meets specific criteria to include completion of a 3 month course of conservative therapy, imaging studies confirm the patient's pathology, and significant clinical findings noted by exam. No imaging studies were submitted confirming the patient's rotator cuff tear. No information was submitted regarding the patient's specific complaints of pain with active arc of motion. Given these findings, this request is not indicated. As such, it is the opinion of this reviewer that the requested left shoulder diagnostic arthroscopy/SAD/rotator cuff repair/synovectomy/treatment as indicated proximal bicep tenotomy/tenodesis/extensive debridement 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
- AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- 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)