

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

May/27/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left shoulder arthroscopy with superior labrum anterior and posterior and rotator cuff repair versus debridement with SAD bursectomy

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

Board Certified Orthopedic Surgeon

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 left shoulder. The MRI of the left shoulder dated [redacted] revealed an acute partial thickness intrasubstance tear of the distal supraspinatus tendon. The tear extends in a laminar configuration from the anterior and mid-humeral attachment proximally over a length of 9mm. A SLAP tear was identified within the glenoid labrum. Mild degenerative hypertrophy was also identified at the left acromion clavicular joint. The clinical note dated 11/14/13 indicates the patient complaining of left shoulder pain. Upon exam, the patient was able to elevate the arm to 90 degrees actively and 175 degrees of passive range of motion. The clinical note dated 11/21/13 indicates the patient having been recommended for a subacromial injection. The patient did show some improvement with elevation to 100 degrees actively. The patient was provided with a Xylocaine injection into the subacromial space at that time. The patient did report good relief following the injection. The therapy note dated 11/25/13 indicates the patient having initiated physical therapy. The patient was able to demonstrate 90 degrees of left shoulder flexion, 25 degrees of extension, 75 degrees of abduction, as well as 15 degrees of both internal and external rotation. The patient also demonstrated 3- to 4/5 strength throughout the left shoulder. The clinical note dated 12/12/13 indicates the patient continuing to do well following the injection. No instability was identified at the shoulder. The clinical note dated 03/24/14 indicates the patient being recommended for a surgical intervention. The note indicates the patient having positive Neer's, Hawkins', drop arm, O'Brien's, Speed's, and Jorgensen's tests.

The utilization review dated 04/08/14 resulted in a denial as no information was submitted regarding the patient's significant functional deficits at the shoulder. Additionally, no information was submitted regarding the patient's completion of a full course of conservative therapy.

The utilization review dated 04/22/14 resulted in a denial for a surgical intervention at the left shoulder as no information had been submitted regarding the patient's significant functional deficits.

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 left shoulder arthroscopic superior labral anterior and posterior repair with a rotator cuff repair and subacromial decompression would be indicated provided the patient meets specific criteria to include completion of all conservative treatments. There is an indication that the patient has initiated physical therapy. Additionally, the patient has undergone an injection at the acromioclavicular joint. However, no information was submitted regarding the patient's completion of a full 3 month course of conservative treatments. Given that no information was submitted regarding the patient's completion of a full 3 month course of treatment, this request is not indicated. As such, it is the opinion of this reviewer that the request for a left shoulder arthroscopy with a superior labrum anterior and posterior repair along with a rotator cuff repair versus debridement with a subacromial decompression and a bursectomy is not recommended as medically necessary.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES