

# P-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

May/07/2014

**IRO CASE #:**

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

Right shoulder diagnostic arthroscopy with acromioplasty; Distal clavicle resection, extensive debridement, rotator cuff repair

**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. The clinical note dated 08/26/13 indicates the patient complaining of right shoulder pain that was rated as 7/10. The pain was primarily located at the lateral and posterior aspects of the right shoulder. The patient described the pain as moderate. The patient was instructed to initiate physical therapy at that time. The MRI of the right shoulder dated 09/05/13 revealed a supraspinatus and infraspinatus tendinopathy with articular sided partial thickness tearing. Mild to moderate acromioclavicular joint osteoarthritis was identified. Moderate subacromial subdeltoid bursitis along with minimal glenohumeral joint osteoarthritis was further revealed. The clinical note dated 09/20/13 indicates the patient continuing with mild to moderate pain at the anterior aspect of the right shoulder. Upon exam, the patient was able to demonstrate full flexion with 30 degrees of extension and 180 degrees of abduction. Supraspinatus testing did elicit pain. The therapy note dated 10/17/13 indicates the patient having completed 12 physical therapy sessions to date. The clinical note dated 10/25/13 indicates the patient stating that the physical therapy had provided some improvement and benefit. Mild pain continued at the anterior aspect of the right shoulder. The clinical note dated 12/02/13 indicates the patient having complaints of night time pain. The patient described the pain as an aching sensation. Upon exam, the patient had a positive Hawkins' sign with pain and weakness. The patient also had equivocal findings involving a Speed's and O'Brien's test. The patient continued

with good range of motion. The designated doctor evaluation completed on 02/13/14 indicated the patient showing 4/5 strength throughout the right shoulder. The patient demonstrated positive Apley's, apprehension, Hawkins', and an empty can test. The clinical note dated 02/17/14 indicates the patient continuing to demonstrate full range of motion throughout the right shoulder. Mild palpable tenderness was identified at the anterior aspect of the shoulder.

The utilization review dated 03/04/14 resulted in a denial for the requested procedure as no significant clinical findings had been identified in the clinical documentation.

The utilization review dated 04/04/14 resulted in a denial as no evidence was submitted in the medical reports indicating the patient had exhausted all conservative treatments.

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

The documentation indicates the patient complaining of ongoing right shoulder pain. The clinical exam did reveal a number of provocative exam findings. However, no information was submitted confirming the patient's previous injection therapy at the right shoulder. Without exhaustion of all conservative treatments, a surgical procedure of this nature is not fully indicated at this time. As such, it is the opinion of this reviewer that the request for a right shoulder diagnostic arthroscopy with acromioplasty; distal clavicle resection, extensive debridement, rotator cuff repair 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)