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An Independent Review Organization

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Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Left shoulder arthroscopic decompression of the rotator cuff and repair of the tendon

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)

Patient Clinical History (Summary)

The patient is a male who sustained an injury on xx/xx/xx. The patient developed complaints of pain in the left shoulder with limited range of motion. The patient was followed for continuing complaints of left shoulder pain. reported cortisone injection at the left shoulder on 11/04/14. The patient was referred back to physical therapy on this date. Clinical record from 11/20/14 indicated the patient had persistent left shoulder pain despite injections and physical therapy. Physical examination noted significant tenderness over the rotator cuff with limited range of motion on abduction and rotation. No specific measurements were provided. There were positive impingement signs noted with weakness in the left shoulder due to pain and loss of range of motion. MRI of the left shoulder from 09/25/14 showed evidence of a small tear in the anterior most supraspinatus tendon at the insertion site which did not appear to be full thickness. There was intermediate signal intensity within the mid portion of the supraspinatus consistent with tendinosis. No other rotator cuff tears were identified. The labrum appeared normal and there was no abnormality of the long head of the biceps tendon. The submitted request for left shoulder arthroscopic decompression of the rotator cuff with repair of the tendon was denied on 10/08/14 and 10/30/14 due to the lack of clinical documentation of conservative treatment.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient has had persistent complaints of left shoulder pain despite injections and reported physical therapy. MRI of the left shoulder noted partial thickness tear of the distal supraspinatus tendon at the insertion. This tear was not full thickness as no retraction was evident. Per guidelines for partial thickness rotator cuff tears conservative treatment is recommended for at least three to six months. Clinical documentation noted some physical therapy and injection to an unspecified site. It is unclear if a diagnostic injection was performed at the subacromial space as recommended by guidelines. It is unclear to what extent physical therapy was completed to date and without clinical documentation of at least three months of conservative treatment failure it is the opinion of this reviewer that medical necessity is not established and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)

- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)