

C-IRO Inc.

An Independent Review Organization

1108 Lavaca, Suite 110-485

Austin, TX 78701

Phone: (512) 772-4390

Fax: (512) 519-7098

Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/05/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left shoulder scope RTC debridement vs repair

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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 request for left shoulder scope RTC debridement vs repair is recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury to her left shoulder on xx/xx/xx. X-rays of the left shoulder dated 07/02/14 revealed essentially normal findings at the left shoulder. A clinical note dated 07/02/14 indicated the patient complaining of lateral right shoulder and anterior left shoulder pain. The patient reported numbness in the right hand. Upon exam, the patient demonstrated 85 degrees of left shoulder abduction. Pain was elicited upon palpation at the anterior portion of the left shoulder. The patient was prescribed cyclobenzaprine and naproxen for pain relief. The therapy evaluation dated 07/28/14 indicated the patient rating left shoulder pain 7/10. The patient had significant his surgical history involving the left shoulder with subacromial decompression in 2011. The patient demonstrated 90 degrees of flexion, 70 degrees of abduction, and 60 degrees of external rotation. A clinical note dated 07/18/14 indicated the patient was referred to physical therapy to increase range of motion in bilateral shoulders. The patient was advised to not lift any object heavier than 10 pounds. Clinical note dated 08/08/14 indicated the patient completing three physical therapy sessions to date. The patient continued with light duty.

The patient utilized ibuprofen for pain relief. MRI of the bilateral shoulders dated 08/28/14 indicated the patient showing the appearance of partial with full thickness rotator cuff tears. Injury was identified at the biceps anchor on the left. Interosseous lesion was revealed at the humeral head with non-displaced fracture. Extensive tears were identified at the supraspinatus and infraspinatus tendons on the left. A clinical note dated 09/04/14 indicated the patient demonstrating 60 degrees of flexion and abduction in bilateral shoulders. The patient continued ibuprofen. The Utilization Reviews dated 10/30/14 and 12/08/14 resulted in denials as insufficient information was submitted regarding completion of a full course of conservative treatment.

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

The request for left shoulder scope and rotator cuff debridement is certified. The patient complained of left shoulder pain with associated range of motion deficits. Rotator cuff repair is indicated provided that the patient meets specific criteria, including imaging studies confirming significant pathology. The most recent MRI revealed significant and extensive tears of the supraspinatus and infraspinatus at the left shoulder. The patient had involvement of the biceps anchor. Given the appearance of full thickness tear of supraspinatus and infraspinatus tendons and significant range of motion deficits throughout the left shoulder this request is reasonable. As such, it is the opinion of this reviewer that the request for left shoulder scope RTC debridement vs repair is recommended as medically necessary and the prior denials are overturned.

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)