

IRO Express Inc.

An Independent Review Organization

Phone Number:
(682) 238-4976

2131 N Collins PMB 433409

Arlington, TX 76011

Email: iroexpress@irosolutions.com

Fax Number:
(817) 385-9611

Notice of Independent Review Decision

Notice of Independent Review Decision

Case Number:

Date of Notice: 09/25/2015

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:

Right rotator cuff repair scope, arthroscopic surgical shoulder; repair of slap lesion claviclectomy, partial

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 xxxx. On xxxxx, she was taken to surgery for a preoperative diagnosis of right rotator cuff tear, and procedure performed was a decompression with a rotator cuff tear and partial bursectomy to the right shoulder. On 10/29/14, the patient returned to clinic with continued right shoulder pain despite the rotator cuff repair. She had 3/4 range of motion and after a steroid injection she tolerated range of motion which increased to 4/4. On 12/08/14, the patient returned to clinic and noted being better after the injection, and she was undergoing work hardening. On 04/20/15, an MRI of the right shoulder was obtained revealing hardware along the anterior greater tuberosity resulting in artifact limiting evaluation of the supraspinatus. The remaining tendons appeared to be intact and there was mild atrophy of the supraspinatus indicated. There was mild AC and glenohumeral joint degenerative arthrosis. On 07/29/15, the patient returned to clinic. It was noted she had pain ever since the previous surgery and had been diagnosed with an anterior labral tear. It was noted the MRI of 05/04/15 suggested a labral tear that had been initially missed in an earlier MRI. Arthroscopic repair of the labrum was recommended.

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

On 07/07/15, a utilization review determination letter was submitted for the requested rotator cuff repair scope, arthroscopic surgical shoulder, repair of SLAP lesion, claviclectomy, partial, and noted the request was non-certified.

Criteria used were the Official Disability Guidelines shoulder chapter updated on 05/04/15. The rationale given was that there was mention of an unofficial MRI performed on 05/04/15 which showed a labral tear but the official MRI provided in the medical records, dated 04/20/15, did not provide findings indicating a SLAP lesion to warrant the requested repair of a SLAP lesion. Initially, there was no documentation indicating that this patient had any imaging findings of severe degenerative joint disease of the AC joint as well as complete or incomplete separation of the AC joint to warrant the requested partial claviclectomy. Therefore the request was non-certified.

For this review, an MRI of the right shoulder dated 09/20/14 was submitted for review noting the acromion morphology is type 1, and no labral defect is appreciated. The MRI report of 04/20/15 was submitted, noting mild AC joint degenerative arthrosis noted, and there is no indication of a labral tear. The provider on 05/06/15 noted that an imaging study in the form of an MRI on 05/04/15 suggested a labral tear that may

have been initially missed. That official MRI report was not submitted for this review. The most recent MRI submitted for this review dated 04/20/15, notes mild AC joint and glenohumeral degenerative arthrosis, and there is an artifact limiting evaluation of the supraspinatus but the remaining tendons appeared to be intact. Thus, there is lack of a rationale for a rotator cuff repair, or repair of a SLAP lesion or for the claviclectomy. It is the opinion of this reviewer that the request for a right rotator cuff repair scope, arthroscopic surgical shoulder, repair of a SLAP lesion, claviclectomy partial is not medically necessary 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)