P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 779-3287
Fax: (888) 350-0169
Email: manager@p-iro.com

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left revision shoulder arthroscopy with extensive debridement, capsular release, tenolysis, loose body removal, revision rotator cuff repair, superior capsular reconstruction and dermal allograft augmentation

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

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a now XXXX with a history of an occupational claim from XXXX. The mechanism of injury was not listed in the recent clinical documentation. The patient was diagnosed with incomplete tear of rotator cuff of the left shoulder, and status post left revision scope. An MRI of the left upper extremity performed on XXXX revealed large joint effusion extending into the subacromial and subdeltoid bursa secondary to a complete rupture and retraction of the supraspinatus and infraspinatus. There was diffuse tendinopathy, worsened compared to the prior study. Joint effusion had increased. The biceps tendon was markedly attenuated, consistent with tendinitis and/or partial tear within the bicipital groove. There was glenohumeral joint arthropathy with partial loss of articular and labral cartilage, acromioclavicular joint arthropathy without change, and marrow edema. On XXXX, the patient presented for follow-up with ongoing, increasing shoulder pain. The pain was exacerbated by movement. The provider noted a history of status post left shoulder scope with subscapularis repair and rotator cuff repair. On examination, range of motion was 130° of forward flexion and 30° of external rotation. Rotator cuff strength was 3/5 with supraspinatus testing. There was no popping noted. The treatment plan included recommendation to proceed with surgery. The provider noted that the patient had activity limiting shoulder pain which has not improved with conservative treatments including medications, physical therapy, and a cortisone injection. The recommendation was made for left revision shoulder arthroscopy with debridement, capsular

release, tendon lysis, loose body removal, revision rotator cuff repair, superior capsular reconstruction, and dermal allograft augmentation. The requested surgical procedure was most recently reviewed on XXXX. The requested surgery was denied as there was no updated MRI initially provided for review and given that superior capsular reconstruction is considered investigational or guidelines.

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

Regarding the requested left revision shoulder arthroscopy with extensive debridement, capsular release, tenolysis, loose body removal, revision rotator cuff repair, superior capsular reconstruction and dermal allograft augmentation, the available documentation indicated that the surgical request was previously denied as no updated imaging was provided for review and given that not all surgical procedures were recommended by guidelines. Upon review of the available documentation, the patient did have an updated MRI report dated XXXX provided for review, confirming complete rupture and retraction of the supraspinatus and infraspinatus, as well as diffuse tendinopathy, increased joint effusion, attenuated biceps tendon, acromioclavicular joint arthropathy, and glenohumeral joint arthropathy. The patient presented with decreased range of motion on examination, and motor strength weakness. However, superior capsular reconstruction is not recommended by guidelines due to a lack of sufficient studies indicating efficacy. As not all procedures are recommended by guidelines, the request for surgery is not supported.

Therefore, left revision shoulder arthroscopy with extensive debridement, capsular release, tenolysis, loose body removal, revision rotator cuff repair, superior capsular reconstruction and dermal allograft augmentation is not medically necessary, and the prior determination is upheld.

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

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Shoulder, Surgery for adhesive capsulitis ODG Indications for Surgery™ -- Adhesive capsulitis: