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IRO Certificate #XX

DATE OF REVIEW: 2/23/18

IRO CASE NO. XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient surgery for Left Shoulder Arthroscopy & Post Op Brace: 29807 29819 29823 29824 29825 29826 29827 29828 L3960

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

Physician Board Certified in Orthopedic Surgery

REVIEW OUTCOME

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

Upheld	**(Agree)**	**X**
Overturned	(Disagree)	
Partially Overturned	(Agree in part/Disagree in part)	

PATIENT CLINICAL HISTORY SUMMARY

Patient XXXX work, XXXX, injuring XXXX shoulder on left side. XXXX presented on XXXX to XXXX with shoulder pain on the left, worse with physical activity, working, over activity, and lifting. The encounter note states that patient had not had previous physical therapy or previous surgeries. It was also stated that patient has been taking Tylenol. XXXX diagnosis was adhesive capsulitis. An MRI was ordered XXXX

XXXX saw the patient again on XXXX. XXXX continued to have left shoulder pain which was getting worse. The note states no physical therapy. Patient still taking Tylenol. MRI results were reviewed and revealed left shoulder high grade partial rotator cuff tear, partial subscapularis tear, SLAP tear, biceps tendinitis, type II acromion, acromioclavicular joint, osteoarthritis, and adhesive capsulitis. Note states patient had received physical therapy. Review of notes do not document any physical therapy visits. Also states the patient did not want a cortisone injection. XXXX recommended surgery.

Patient was again seen by XXXX on XXXX; patient reporting shoulder pain. Note states no previous physical therapy and treatment with Tylenol only reported. Diagnosis the same as earlier. Once again, XXXX recommended surgery and physical therapy.

MRI of the left shoulder without contrast was performed XXXX showing no fracture, AVN, or abnormal

marrow. XXXX had a type II acromion with moderate osteoarthritis of the acromioclavicular joint. There was a moderate joint effusion with debris, normal cartilage. There appeared to be abnormal morphology of the superior labrum.

PATIENT CLINICAL HISTORY SUMMARY (continuation)

Noted was a high grade partial thickness undersurface tear of the anterior to mid supraspinatus tendon measuring .06 cm with probable full-thickness component. There is superimposed tendinosis. There is tendinosis of the infraspinatus. There's partial thickness undersurface tear of the subscapularis with tendinosis and normal teres minor. The long head of the biceps tendon appeared abnormal. There was mild edema in the rotator interval.

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

Opinion: I agree with the benefit company's decision to deny the requested service.

Rationale: I feel that a significant portion of patient's left shoulder pathology is degenerative, including the type II acromion, degenerative changes of the acromioclavicular joint, and tendinosis. The partial thickness tear of the supraspinatus and labral tear could be secondary to a work injury. I recommend non-operative management with formal physical therapy and a subacromial, and possible glenohumeral, steroid injection for pain relief. I do not recommend surgical intervention at this time.

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

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE
AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X
MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
MILLIMAN CARE GUIDELINES
ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X
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 DESCRIPTION)
OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)