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IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Arthroscopic decompression and arthroscopic debridement; shoulder immobilizer right shoulder

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Orthopedic Surgeon

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

[X] Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XX year old XX who was injured on XXXX and had been followed for complaints of right shoulder pain. The claimant was assessed with a right shoulder rotator cuff repair and is status post repair with a subacromial decompression and Mumford procedure dated XXXX. The claimant did attend post-operative physical therapy following surgery. The claimant described ongoing pain and stiffness following surgery. The claimant did report some improvement in pain with the use of NSAIDs. The claimant reported short term relief with additional subacromial injections. The claimant did have a MR arthrogram study completed on XXXX and the addendum report noted a small articular surface tear of the infraspinatus near the insertion that was a new finding. There was moderate tendinosis noted. The XXXX clinical report noted limited right shoulder range of motion in all planes. There were positive impingement signs noted. There was tenderness to palpation anteriorly. The planned debridement and decompression with a right shoulder immobilizer was denied by utilization review which noted lack of imaging findings to support surgery.

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

The claimant has been followed for persistent right shoulder pain status post rotator cuff repair and subacromial decompression performed in XXXX. The claimant has attended physical therapy and received injections without long term relief. The claimant had short term relief only with medications. The claimant's MR arthrogram addendum did confirm that the claimant had a partial thickness infraspinatus tear and tendinosis. The claimant's physical exam findings continued to note positive impingement signs. Given the claimant's lack of response to non-operative measures following the index rotator cuff repair performed in XXXX, as well as the ongoing evidence of symptomatic

impingement and loss of range of motion, it is this reviewer's opinion that medical necessity is established and the prior denials are overturned.

IRO REVIEWER REPORT TEMPLATE -WC

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

[X] **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

[X] **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**