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IRO Certificate #4599

DATE OF REVIEW: 4/02/18
IRO CASE NO. XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Left shoulder Arthroscopy, Subacromial Decompression, Distal Clavicle Excision Debridement, Rotator Cuff Repair, Labral Repair, Biceps Tenodesis; 23412, 23430, 29807, 29823, 29824, 29826

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)

Overturned (Disagree

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

PATIENT CLINICAL HISTORY SUMMARY
XX reports an injury on the job in XXXX. XX describes XX while at work. The job does require XX. Initial provider used anti-inflammatories and muscle relaxers followed by a course of physical therapy. Subsequent MRI showed evidence of a partial articular surface tear of the supraspinatus described as near full thickness. This extends into the infraspinatus. Tendinosis and small partial tearing of the subscapularis noted as well. Superior labral tear described and extending into the biceps reported. Glenohumeral join effusion with mild glenohumeral arthrosis and AC joint arthrosis. Referral to the orthopedist who notes patient getting temporary relief, but still having pain. Above surgery recommended (Left shoulder Arthroscopy, Subacromial Decompression, Distal Clavicle Excision Debridement, Rotator Cuff Repair, Labral Repair, Biceps Tenodesis). Authorization denied secondary to lack of preoperative trial of steroid injections. This was subsequently performed on XXXX. Continuation of home exercise program recommended. Follow-up visit found no significant improvement. Surgery once again requested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION
Opinion: I agree/partly disagree with the benefit company's decision to deny the requested service.

Rationale: At this time, patient approaching XX after on-the-job injury. XX is not making clinical improvement. I **agree** with recommendations to proceed with arthroscopy for possible debridement, labral repair, subacromial decompression, and rotator cuff repair and **consider this to be medically necessary**.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (continuation)
However, I see no evidence that the AC joint has been evaluated clinically for symptomology and, thusly, is not medically necessary. I recommend this portion of the procedure be denied, despite evidence of degenerative changes on MRI scan. Certainly, if further clinical encounters document signs and symptoms referrable to pathology at the AC joint, recommendations could be altered.

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)