

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Mar/19/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** right shoulder arthroscopy with debridement and possible subscapularis repair

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D. Board Certified Orthopedic Surgeon

**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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of this reviewer that medical necessity is not established for right shoulder arthroscopy with debridement and possible subscapularis repair.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Adverse determination letter dated 01/11/13

Adverse determination letter dated 01/28/13

Fax transmittal dated 02/07/12

Office notes dated 01/30/12 – 02/22/13

Office notes dated 03/22/10

MR arthrogram right shoulder dated 03/11/10

Operative report dated 04/01/10

Physical therapy progress report dated 04/12

Surgery orders dated 02/25/13 and 01/08/13

Appeal request right shoulder arthroscopy dated 01/14/13

MRI lumbar spine dated 10/11/11

**PATIENT CLINICAL HISTORY [SUMMARY]:** The claimant is a male who was reportedly injured on xxxxx when he slipped and fell and struck his right shoulder and low back. The patient was noted to have a history of previous right shoulder surgeries. MR arthrogram of the right shoulder performed on 03/11/10 revealed postoperative changes with moderate supraspinatus tendinosis without evidence of a high-grade partial or full-thickness tear. On 04/01/10, the claimant underwent right shoulder surgery with SLAP repair, rotator cuff repair, subacromial decompression, and biceps tenodesis. Records indicate that the claimant underwent resurfacing arthroplasty of the right shoulder on 02/20/12 but continues to have pain despite physical therapy and activity modifications. MRI reportedly was performed on 10/24/12, but no radiology report was provided. The claimant was recommended to undergo diagnostic arthroscopy with repair/debridement as indicated.

A request for right shoulder arthroscopy with debridement and possible subscapularis repair

was non-certified on 01/11/13, noting that diagnostic criteria had not been met per guideline recommendations. Guidelines indicated that for rotator cuff repair, diagnostic evidence of rotator cuff tear and of deficit in rotator cuff should be documented. MRI provided for review documented no evidence of rotator cuff tear. There was no clinical documentation of significant deficit on physical examination. Guidelines indicated that objective weakness or absent abduction should be noted in addition to muscular atrophy, which was not provided in the records reviewed. It was further noted that although post-operative physical therapy had been performed the records provided had not noted evidence of therapy and associated response or documentation of corticosteroid injections. Guidelines stated that full conservative treatment for three to six months including physical therapy should be provided prior to proceeding with surgical intervention.

A reconsideration request for right shoulder arthroscopy with debridement and possible subscapularis repair was non-certified as medically necessary on 01/28/13 following peer to peer discussion. It was noted that the claimant continued to have symptoms after hemiarthroplasty in 02/12. He had a course of physical therapy, but conservative treatment had not been exhausted. It was noted that guidelines indicated that for rotator cuff repair diagnostic evidence of rotator cuff tear or deficit in the rotator cuff should be documented, and the MRI provided for review documented no evidence of rotator cuff tear. There also was no documentation of significant deficit on physical examination. The records reviewed did not provide evidence of objective weakness or absent abduction, in addition to muscular atrophy. Although post-operative physical therapy had been performed per the records, associated response or documentation of corticosteroid injection was not documented; therefore, conservative treatment documentation had not been provided.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The records submitted for review document that the claimant sustained an injury secondary to slip and fall on xx/xx/xx. He has a history of previous right shoulder surgeries. The claimant underwent surgical intervention on 04/01/10 with SLAP repair, subacromial decompression, and rotator cuff repair. The patient also underwent hemiarthroplasty of the right shoulder on 02/20/12 followed by post-operative physical therapy. However, there is no comprehensive history documenting the total number of physical therapy visits completed, modalities used, and response to treatment. There also is no indication of other conservative measures including corticosteroid injection. Per the previous reviews, MRI submitted for review did not demonstrate a rotator cuff tear, and no significant deficit was documented on physical examination. Based on the clinical data provided, noting the lack of documentation that lower levels of care including therapy and corticosteroid injections have been exhausted, noting the lack of objective evidence of significant rotator cuff tear on MRI, and noting the absence of or the lack of and noting no significant deficit on physical examination, it is the opinion of this reviewer that medical necessity is not established for right shoulder arthroscopy with debridement and possible subscapularis repair.

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

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-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 JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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 A DESCRIPTION)

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