

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jul/15/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** right shoulder arthroscopy with rotator cuff 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 therefore the opinion of this reviewer that the request for right shoulder arthroscopy with rotator cuff repair is not medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Request for IRO dated 06/21/13

Receipt of request for IRO dated 06/21/13

Utilization review determination dated 05/01/13

Utilization review determination dated 06/04/13

MRI of the right shoulder dated 01/21/13

Diagnostic interpretation dated 04/24/13

Clinical note dated 04/24/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The claimant is a female who is reported to have injured her right shoulder while mopping on xx/xx/xx. It is reported that while mopping the floor, she experienced a popping sensation in her right shoulder. Records indicate that the claimant was referred for an MRI of the right shoulder dated 01/21/13. This study notes evidence of a partial thickness bursal surface tear of the distal supraspinatus tendon with no full thickness rotator cuff demonstrated. There was moderate fluid in the subacromial/subdeltoid bursa consistent with bursitis. There is evidence of a sprain at the superior and inferior AC joint ligaments with no abnormality of the coracoclavicular ligament. On 04/24/13, the claimant was seen. reports that the claimant is unimproved with conservative treatment and notes that the claimant underwent a right shoulder Cortisone injection without improvement. She is reported to have undergone a course of physical therapy and is taking medication. On physical examination, it is reported that there is moderate restriction in abduction, moderate restriction in external rotation, and moderate restriction in internal rotation of the right shoulder. There is tenderness of the right biceps tendon. Supraspinatus test is positive on the right and negative on the left. The claimant was opined to have a right shoulder impingement syndrome and a partial rotator cuff tear and

subsequently was recommended to undergo surgical intervention to consist of arthroscopy and rotator cuff repair.

The initial review of the request was performed on 05/01/13. At this time, the reviewer non-certifies the request noting that treatment guidelines for subacromial decompression require from 3 to 6 months of conservative treatment. The reviewer notes that the medical records do not support that there has been appropriate conservative treatment. It is further noted that the claimant would not meet criteria based on the treatment guidelines for partial thickness tear as there is insufficient clinical information to establish the failure of conservative management and that the claimant's physical examination is not supportive of the need for surgical intervention.

A subsequent appeal request was performed on 06/04/13. The reviewer notes that the previous non-certification stated that the medical records do not support that there has been 3 to 6 months of conservative treatment with physical therapy or oral medications. The reviewer notes that the claimant does not meet criteria due to a lack of lower levels of conservative care being exhausted and the use of anti-inflammatory medications has not been documented. He notes that there is still no documentation as required by the guidelines. He subsequently upholds the prior denial.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The submitted clinical records indicate that the claimant is a female who sustained an injury to her right shoulder while mopping. The submitted clinical record is minimal and consists of a single note from the requester and MRI of the right shoulder dated 01/21/13. This study notes that there is a partial thickness bursal tear of the distal supraspinatus with evidence of a subacromial subdeltoid bursitis and evidence of sprain to the superior and inferior AC joint ligaments. No supporting documentation from the claimant's initial treating provider, was provided for review. The claimant is reported to have undergone a Cortisone injection; however, no records were provided to establish the performance of the injection as well as the claimant's response. The claimant is further reported to have undergone a course of physical therapy, but no supporting documents were provided. The submitted physical examination notes limitations in range of motion and tenderness with a positive supraspinatus test. No other orthopedic tests or specific measurements of range of motion to include active and passive range of motion were provided. There is no indication that the claimant has undergone an appropriate course of anti-inflammatory medications. As such, the claimant clearly does not meet Official Disability Guidelines criteria for the requested procedure. It is therefore the opinion of this reviewer that the request for right shoulder arthroscopy with rotator cuff repair is not medically necessary and prior utilization review determinations were appropriate and consistent with the Official Disability Guidelines and therefore, upheld.

**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)**