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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/19/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: arthroscopy, shoulder, surgical; 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 this reviewer's opinion that medical necessity is not established for the requested arthroscopy, shoulder, surgical; with rotator cuff repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Laboratory studies dated 05/08/12
EKG dated 05/08/12
Physical therapy reports dated 04/25/13 – 05/21/13
Clinical notes dated 05/08/12 – 04/03/13
MRI of the right shoulder dated 05/07/13
Designated doctor evaluation dated 04/01/13
Appeal letter dated 05/22/13
Prior reviews dated 05/13/13 & 05/28/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx when he fell down a flight of stairs injuring his right shoulder. Per the designated doctor evaluation on 04/01/13, the patient did have prior physical therapy in 2012 as well as MRI scans of the right shoulder. Prior MRI studies demonstrated a complete disruption of the supraspinatus and superior fibers of the infraspinatus tendon. The patient did undergo a right shoulder rotator cuff repair on 08/29/12 with acromioclavicular joint resection and distal clavicle excision. The patient did attend a postoperative physical therapy program. However, there was some interruption in care due to a move from to. Physical therapy was not sufficiently restarted. The patient reported ongoing complaints of constant right shoulder pain at this visit. Physical examination demonstrated decreased strength in the right shoulder musculature with positive impingement signs noted. The patient was felt not to have met maximum medical improvement and was recommended for additional physical therapy. The patient did attend further physical therapy through May of 2013. Clinical report on 04/03/13 stated that the patient has had continued difficulty with range of motion in the right shoulder. There was difficulty assessing the patient's weakness. The patient was recommended for

updated MRI studies of the right shoulder which were performed on 05/07/13. The study revealed a re-tear of the repaired supraspinatus tendon that was full thickness at the level of acromion. There was also full thickness tearing of the anterior fibers of the infraspinatus tendon. There was a mild to moderate amount of fatty atrophy present in the supraspinatus and infraspinatus musculature.

The request for right shoulder arthroscopy with rotator cuff repair was denied by utilization review on 05/13/13 as MRI studies did not show any evidence of impingement.

The request was again denied by utilization review on 05/28/13 as there were no injections performed to date.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for ongoing complaints of right shoulder pain with a notable recurrent full thickness rotator cuff tear through the infraspinatus and supraspinatus tendons. The MRI studies of the right shoulder recently performed demonstrated fatty atrophy of the rotator cuff musculature. Although the patient does have continued weakness and loss of range of motion in the right shoulder secondary to the recurrent right shoulder rotator cuff tear, the extent and chronicity of the rotator cuff repair would not be reasonably amenable to surgical repair. It is very unlikely that the patient would be able to have a sustainable rotator cuff repair at this point in time due to the extent of the fatty atrophy of the rotator cuff musculature. In all reasonable likelihood, if the patient were to have a repair, this would fail and the patient would not have any significant benefit from the surgical procedures. It is more reasonable to consider waiting for future consideration of a possible total reverse shoulder arthroplasty. Ultimately, the chronicity of the rotator cuff repair does not support surgical intervention at this time and it is this reviewer's opinion that medical necessity is not established for the requested arthroscopy, shoulder, surgical; with rotator cuff repair. As such, the prior denials are 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 KNOWLEDGBASE

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)