

# C-IRO Inc.

An Independent Review Organization

1108 Lavaca, Suite 110-485

Austin, TX 78701

Phone: (512) 772-4390

Fax: (512) 519-7098

Email: resolutions.manager@ciro-site.com

## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/28/2013

IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** right shoulder arthroscopy EUA, DX arthroscopy with debridement, SAD mumford +/- rotator cuff +/- SLAP repair 23120 29822 29825 29876 7 cooling unit / CPM Unit Don Joy immobilizer with pillow (supplies – PNR)

**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 the reviewer that medical necessity for right shoulder arthroscopy EUA, DX arthroscopy with debridement, SAD mumford +/- rotator cuff +/- SLAP repair 23120 29822 29825 29876 7 cooling unit / CPM Unit Don Joy immobilizer with pillow (supplies –PNR) is not established

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

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical note dated 04/02/12

Radiographs right shoulder dated 04/02/12

MRI right shoulder dated 04/19/12

Clinical note dated 04/26/12

Clinical notes dated 05/04/12 – 11/28/12

Radiographs right shoulder dated 05/04/12

Electrodiagnostic studies dated 06/28/12

Operative report dated 09/13/12

Physical therapy evaluations dated 05/11/12 and 09/18/12

Prior reviews dated 01/16/13 and 02/04/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who was involved in a motor vehicle accident on xx/xx/xx. The patient reported wearing a seat belt; however, following the accident, the patient had significant pain while trying to lift his right upper extremity. The patient was initially seen on 04/02/12 with continuing right upper extremity pain that did not respond to Motrin. Radiographs of the right shoulder completed on 04/02/12 revealed no acute fractures. There was lateral down sloping noted at the acromion. MRI of the right shoulder dated 04/19/12 revealed a type II acromion without evidence of degenerative changes within the acromioclavicular joint. The rotator cuff appeared normal and there was a

small hyper-intense signal at the anterior superior aspect of the cartilaginous labrum near the insertion of the biceps tendon consistent with a prominent sub-labral foramen rather than a SLAP lesion. The patient had no significant improvements with the use of oral narcotics. The patient was referred for physical therapy in 05/12. Follow-up on 06/04/12 indicated that the patient had minimal improvement with physical therapy and continued to be unable to lift objects. Physical examination at this visit revealed limited active range of motion on forward flexion to 95 degrees. Passively, the patient could achieve 130 degrees. There were positive impingement signs as well as positive O'Brien's and drop arm signs. The patient was recommended for right shoulder arthroscopy at this visit; however, electro-diagnostic studies were recommended to rule out any radiculopathy given the patient's positive Spurling's sign. Electro-diagnostic studies completed on 06/28/12 revealed a right C6 radiculopathy. The patient was recommended for manipulation under anesthesia which was completed on 09/13/12. The patient also had a right shoulder injection performed during the procedure. Follow-up on 09/26/12 stated that the patient had improvements in right shoulder range of motion but still had limitations and pain in the right shoulder. Physical examination on 09/26/12 revealed limited range of motion on rotation of the right shoulder. The patient was recommended to continue with physical therapy and anti-inflammatories. Follow-up on 11/28/12 stated that the patient continued to have limited range of motion in the right shoulder. Physical examination revealed continuing limited range of motion in the right shoulder actively secondary to pain. There were positive impingement signs with tenderness over the right acromioclavicular joint. Positive drop arm test was noted.

The request for right shoulder surgery to include subacromial decompression, Mumford procedure, rotator cuff repair, and SLAP repair was denied by utilization review on 01/16/13 as there was no documentation regarding updated MRI studies of the right shoulder and limited documentation regarding maximized conservative treatment. Additionally, a CPM unit was not indicated as medically necessary for postoperative use for the shoulder.

The request was again denied by utilization review on 02/04/13 as there was limited documentation regarding postoperative conservative treatment and lack of recent imaging for the right shoulder.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** Based on the clinical documentation provided for review, the patient has persistent limited range of motion in the right shoulder despite physical therapy, use of medications, and manipulation under anesthesia. No recent imaging of the right shoulder was provided for review documenting evidence of any pathology in the right shoulder that would reasonably require any of the requested procedures. The MRI of the right shoulder from 04/12 was relatively unremarkable with only a small focus of signal intensity at the biceps tendon and labral junction. No significant osteoarthritis in the shoulder was noted and the rotator cuff appeared intact. There was no evidence of any SLAP lesions that would reasonably require surgical intervention. Given the lack of any updated imaging showing pathology that would reasonably be amenable to the requested surgical procedures, it is the opinion of the reviewer that medical necessity for right shoulder arthroscopy EUA, DX arthroscopy with debridement, SAD mumford +/- rotator cuff +/- SLAP repair 23120 29822 29825 29876 7 cooling unit / CPM Unit Don Joy immobilizer with pillow (supplies –PNR) is not established and 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 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)**