



Notice of Independent Review Decision

DATE OF REVIEW: 11/7/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical necessity for the previously denied left rotator cuff repair.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas Licensed 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)

The previously denied request for left rotator cuff repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- **Response to Request for IRO Letter dated 10/24/07.**
- **Utilization Review Outpatient dated 10/22/07.**
- **Cover Sheet HCWCNC Required Information dated 10/22/07.**
- **Case Assignment dated 10/19/07.**
- **Letter Cover Sheet Attached Forms dated 10/19/07.**
- **Confirmation of Receipt of a Request dated 10/18/07.**
- **Request Review by an Independent Review dated 10/5/07.**
- **Determination Recommendation dated 8/29/07, 8/17/07, 7/16/07 .**
- **Communication dated 8/23/07, 8/16/07, 7/5/07.**

- **Follow-Up dated 8/21/07, 5/12/04.**
- **Pre-Authorization Form dated 8/15/07, 7/3/07, 5/21/07, 8/20/02.**
- **Pre-Authorization for Therapy dated 7/22/02, 6/28/07, 6/3/07, 11/5/02, 8/2/02, 5/8/02, 11/9/01, 10/25/01.**
- **Left Shoulder MRI dated 6/19/07, 7/24/97, 2/12/03, 4/11/02.**
- **Left Shoulder MRI Arthrogram dated 2/12/03**
- **MRI Report dated 4/17/02, 4/11/02.**
- **Patient Medical dated 4/12/02, 4/11/02, 12/19/00.**
- **Progress Notes dated 6/4/07, 3/21/07, 11/13/06, 10/31/06, 3/7/02, 2/5/02, 10/19/06.**
- **Progress Report dated 1/9/02.**
- **Receipt of Request Letter dated 7/19/06.**
- **Letter of Medical Necessity dated 12/24/05, 3/7/02, 10/5/99, 8/18/99, 2/10/03, 11/18/02, 8/29/02, 8/6/02, 8/1/02, 7/2/02, 6/6/02, 5/16/02, 5/14/02, 5/10/02, 1/9/02, 5/2/02, 11/15/01, 9/6/01, 6/5/01, 6/4/01, 5/4/01, 2/6/01, 6/25/99, 8/31/99.**
- **Office Note Visits dated 11/11/05, 5/18/05, 5/4/05, 4/4/05, 8/5/03, 5/8/03, 2/24/03, 1/7/03, 12/5/02, 10/23/02, 8/20/02, 7/18/02, 6/20/02, 5/30/02, 3/27/02, 1/23/02, 11/8/01, 9/19/01, 8/15/01, 6/13/01, 5/15/01, 12/13/00, 10/2/00, 7/31/00, 5/23/00, 3/6/00, 12/7/99, 8/10/99, 7/12/99, 6/21/99, 4/8/99, 3/31/99, 12/29/98, 10/27/98, 8/25/98, 5/26/98, 3/31/98, 1/6/98, 12/2/97, 10/28/97, 9/23/97, 8/19/97, 6/30/03, 3/19/01.**
- **Initial Evaluation dated 6/5/97, 7/15/97.**
- **Employee's Request to Change Treating Doctors dated 11/2/05, 9/26/05, 8/29/07, 3/15/04.**
- **DME Prescription dated 10/19/07.**
- **History of Present Illness dated 9/21/07, 4/27/00, 6/6/01, 6/4/01.**
- **Workers Comp IME dated 3/24/05, 8/25/03.**
- **Work Status Report dated 5/11/04, 8/5/03, 5/8/03, 12/5/02, 8/20/02, 5/30/02, 5/16/02, 1/23/02, 11/8/01, 9/19/01, 12/13/00, 10/2/00, 7/31/00, 4/27/00, 6/14/01.**
- **Review Medical Exam dated 4/13/07, 3/1/99, 3/2/99.**
- **Psychotherapy Session dated 12/9/03, 11/25/03, 11/11/03, 7/15/03, 7/9/03, 5/29/03, 5/20/03, 5/6/03, 1/28/03, 1/14/03, 12/17/02, 12/5/02, 11/26/02, 10/8/02, 9/24/02, 9/11/02, 8/27/02, 8/13/02, 7/9/02, 7/2/02, 5/28/02, 6/18/02, 6/4/02, 5/20/02, 3/26/02, 3/16/02, 2/12/02, 2/26/02, 2/12/02, 1/3/02.**
- **Utilization Review (Pre-Certification) dated 11/18/03, 11/15/03.**
- **Service Requested by Attending Physician dated 10/13/03.**
- **Confirmation of Request for Treatment/Service dated 5/8/03, 4/9/03, 4/4/03, 3/7/03, 4/8/03.**
- **Report dated 3/28/03, 5/24/01, 5/21/01, 5/2/01, 8/5/97.**
- **Outpatient Surgery Order dated 3/28/03, 1/25/01.**
- **Prescription dated 3/28/03, 3/29/03, 10/3/01.**
- **Anesthesia Record dated 3/28/03.**
- **Pre-Anesthesia Evaluation dated 3/28/03.**
- **Chest X-Ray dated 3/20/03, 6/3/01.**
- **Patient Information dated 3/20/03, 8/1/97, 4/26/00.**
- **Discharge Summary dated 3/20/03, 6/3/01.**
- **Sinus Rhythm Chart dated 3/20/03, 6/3/01.**

- **Surgery Pre-Authorization Request dated 2/5/03.**
- **Treatment dated 11/26/02.**
- **Medical Advisor Referral Form (unspecified date).**
- **Psychiatric Review dated 11/14/02.**
- **Progress Summary (Shoulder) dated 10/4/02, 9/27/02, 9/17/02, 9/3/02, 8/13/02, 8/6/02, 7/30/02, 7/26/02, 7/16/02, 7/9/02, 7/2/02, 6/25/02, 6/18/02, 6/13/02, 6/7/02.**
- **Shoulder Therapy Flow Sheet dated 10/4/02, 10/3/02, 10/2/02, 10/1/02, 7/30/02, 9/27/02, 9/26/02, 9/25/02, 9/24/02, 9/23/02, 9/6/02, 9/5/02, 9/4/02, 9/3/02, 9/2/02, 8/23/02, 8/22/02, 8/21/02, 8/20/02, 8/19/02, 8/2/02, 8/1/02, 7/31/02, 7/30/02, 7/29/02, 7/26/02, 7/25/02, 7/24/02, 7/27/02, 7/22/02, 7/12/02, 7/11/02, 7/10/02, 7/9/02, 7/8/02, 6/28/02, 6/27/02, 6/26/02, 6/25/02, 6/24/02, 6/21/02, 6/20/02, 6/19/02, 6/18/02, 6/17/02, 6/14/02, 6/13/02, 6/12/02, 6/11/02, 6/10/02, 6/7/02, 6/6/02, 6/5/02, 6/4/02, 6/3/02.**
- **Referral Form dated 8/20/02, 8/18/99, 6/20/02, 5/29/02, 5/2/02, 4/27/01, 7/29/02, 2/1/99.**
- **Primary Therapy Shoulder dated 5/30/02, 8/1/97.**
- **Physician Progress Record dated 6/8/01, 6/7/01, 6/6/01, 6/5/01, 6/4/01.**
- **Physician's Orders dated 6/8/01, 6/7/01, 6/6/01, 6/5/01, 6/4/01, 6/3/01.**
- **Extensive Peer Review/Telephonic Review dated 10/1/99, 7/26/99.**
- **Activity Status Report dated 12/1/97, 11/21/97, 11/11/97, 11/7/97, 1/33/97, 10/31/97, 10/26/97, 10/24/97, 10/21/97, 10/17/97, 10/15/97, 10/13/97, 10/10/97, 10/8/97, 10/6/97, 10/3/97, 10/01/97, 9/29/97, 9/26/97, 9/24/97, 9/22/97, 9/17/97, 9/15/97, 9/8/97, 9/5/097, 9/3/097, 8/29/97, 8/27/97, 8/25/97, 8/22/97, 8/20/97, 7/29/97, 7/25/97, 7/21/97.**
- **Articles (unspecified date).**
- **Pre-Authorization Request (unspecified date).**
- **Fax Cover Sheet dated 7/25/02, 1/4/02, 6/4/01, 5/31/01, 4/24/01, 2/1/01, 1/25/01, 8/1/97, 10/19/07.**
- **Chart Notes dated 9/19/01, 9/11/01, 9/6/01, 9/5/01, 9/4/01, 8/15/01, 8/13/01, 7/18/01, 7/17/01, 7/5/01, 6/25/01, 6/13/01, 6/8/01, 6/5/01, 6/4/01, 5/31/01.**
- **Work/School Status dated 8/19/97, 8/1/97.**
- **Operative Report dated 5/2/02, 4/27/01.**
- **Evaluate and Treat dated 7/29/02.**
- **Medical Management dated 8/25/97.**
- **Physical Examination dated 8/1/97, 11/26/01**
- **Initial Medical Report dated 8/22/97, 8/4/97.**
- **Summary Recommendation dated 7/30/02.**
- **Therapy , for Additional Services dated 7/25/02, 8/31/99.**
- **Workers Comp Evaluation Note dated 5/30/02.**
- **Status Form dated 10/28/97, 9/23/97.**
- **Report of Medical Evaluation dated 6/9/98.**
- **Telephone Call dated 5/11/99.**
- **Letter of Clarification dated 12/30/99.**
- **Medical Services Requested dated 1/26/01.**
- **Emergency Medical Service Hospital Report Form dated 6/3/01.**
- **Lab Test dated 6/8/01, 6/7/01.**

- Patient Summary Report dated 6/7/01, 6/6/01.
- Radiology Final Report dated 6/7/01, 6/5/01, 6/4/01.
- Emergency Nursing Flow Sheet dated 6/3/01.
- Transfer Form dated 6/4/01.
- Admission Record dated 6/4/01.
- Active Medications dated 6/7/01.
- Emergency Physician Record dated 6/3/01.
- Request Authorization Medical Treatment and Testing dated 8/31/07.
- Treatment Sheet/Physicians Order dated 8/23/01, 8/21/01.
- Return Visit dated 8/28/01, 8/23/01.
- Right Wrist X-Ray dated 8/23/01.
- Chest X-Ray dated 8/23/01.
- Lung Scan dated 8/23/01.
- Upper Extremity dated 8/23/01.
- Referral Thank You Letter dated 9/19/01.
- Report of Pain Assessment dated 10/16/01.
- Referral Criteria dated 10/23/01.
- Surgery Notes (unspecified year).
- Adult Emergency Department (unspecified date).
- Work Status (unspecified date).
- Utilization Review Referral Form (unspecified date).

PATIENT CLINICAL HISTORY [SUMMARY]:

Age: xxYears
Gender: Male
Date of Injury: xx/xx/xx
Mechanism of Injury: Not provided for this review.

Diagnosis: Status-post distal clavicle resection and rotator cuff repair, date unknown.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

This xx year old male sustained an undescribed left shoulder work related injury on xx/xx/xx. The mechanism of injury was not provided. The patient subsequently had a surgical procedure consisting of distal clavicle resection and rotator cuff repair, the date of which is unknown., MD, on 6/25/07 stated patient "continues to have left shoulder pain consistent with rotator cuff injury. MRI is significant for a large chronic appearing recurrent supraspinatus tendon rupture. The patient will be cleared for rotator cuff repair..." On 8/6/07, Dr. stated that physical therapy and injections will only contribute minimally and he would continue to require surgery. A left shoulder MRI, dated 6/19/07, stated "There is a large retracted supraspinatus tendon tear with extensive atrophy in the supraspinatus muscle belly suggesting it is of long term duration. Superior subscapularis tendon difficult to visualize. The more inferior portion of the tendon appears intact as do the infraspinatus and teres minor tendons. The humeral head is normally located. Biceps

tendon not visualized. Post operative changes from prior acromioplasty noted." An MR arthrogram of the left shoulder, dated 4/11/02, stated "a high riding and anteriorly subluxed humeral head with a full thickness cuff tear. Also noted was a tear of the anterior aspect of the infraspinatus tendon. The subscapularis tendon also appeared to be torn." The Official Disabilities Guidelines 2007 (ODG) states "surgical outcomes are much better in younger patients with a rotator cuff tear, than in older patients who may be suffering from degenerative changes in the rotator cuff." Indications for rotator cuff repair include: 1. Subjective clinical findings: shoulder pain and inability to elevate the arm...plus, 2. Objective clinical findings: weakness with abduction testing. May also demonstrate atrophy of shoulder musculature, plus 3. Imaging Clinical Findings. The recent treatment records do not describe subjective or objective clinical findings to support a rotator cuff repair. Moreover, the recent shoulder MRI demonstrated a large tear with supraspinatus muscle atrophy, suggesting it is of long term, (dating back at least to 2002 per the prior MRI). Given the above-reference guidelines, and given the available clinical information, repair of a chronic complete rotator cuff tear with associated muscle atrophy is unlikely to be successful in a xx year old patient and is, therefore, not approved.

Addendum 10/31/07: This reviewer was provided extensive additional records that described numerous prior operative procedures performed by Dr.: - 8/5/97- arthroscopic acromioplasty and mini-open rotator cuff repair. - 6/28/99 - operative findings of post-surgical scarring and partial dehiscence of the rotator cuff repair. The operative procedure was extensive debridement and repeat acromioplasty. - 4/27/01 - rotator cuff repair and open acromioplasty/distal clavicle excision - 5/21/01 - exploration noting that the rotator cuff repair was not intact and the deltoid muscle had pulled off the anterior acromion. The operative procedure was debridement of non-viable tissue. - 5/24/01 - repair of rotator cuff repair. - 3/28/03 - the rotator cuff was scarred down, retracted and not amenable to repair. Loose bone and soft tissue fragments were removed and the undersurface of the acromion was smoothed. This additional information describes a total of 6 operations. The last procedure note from 3/28/03 noted that the rotator cuff had retracted, was scarred, and was not amenable to repair. Therefore, consistent with the above comments, the requested rotator cuff tear is not health care reasonably required or consistent with evidence based medicine, and is not approved.

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

- ACOEM – AMERICAN 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.
- X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.**

Official Disability Guidelines, Treatment Index, 5th Edition, 2006/2007
Shoulder-Surgery for Rotator Cuff Syndrome

Recommended as indicated below. Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, but the outcomes from open repair are as good or better. Surgery is not indicated for patients with mild symptoms or those who have no limitations of activities. ([Ejnisman-Cochrane, 2004](#)) ([Grant, 2004](#)) Lesions of the rotator cuff are best thought of as a continuum, from mild inflammation and degeneration to full avulsions. Studies of normal subjects document the universal presence of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment but without surgical risks. Studies evaluating results of conservative treatment of full-thickness rotator cuff tears have shown an 82-86% success rate for patients presenting within three months of injury. The efficacy of arthroscopic decompression for full-thickness tears depends on the size of the tear; one study reported satisfactory results in 90% of patients with small tears. A prior study by the same group reported satisfactory results in 86% of patients who underwent open repair for larger tears. Surgical outcomes are much better in younger patients with a rotator cuff tear, than in older patients, who may be suffering from degenerative changes in the rotator cuff. Referral for surgical consultation may be indicated for patients who have: Activity limitation for more than three months, plus existence of a surgical lesion; Failure of exercise programs to increase range of motion and strength of the musculature around the shoulder, plus existence of a surgical lesion; Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair; Red flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.). Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears are treated the same as impingement syndrome regardless of MRI findings. Outpatient rotator cuff repair is a well accepted and cost effective procedure. ([Cordasco, 2000](#)) Difference between surgery & exercise was not significant. ([Brox, 1999](#)) There is significant variation in surgical decision-making and a lack of clinical agreement among orthopaedic surgeons about rotator cuff surgery. ([Dunn, 2005](#))

ODG Indications for Surgery™ -- Rotator cuff repair:

Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:

1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS

2. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS

3. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS

2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS

3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS

4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

[\(Washington, 2002\)](#)

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or

insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.
