



Notice of Independent Review Decision

DATE OF REVIEW: 10/10/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical necessity for a left shoulder arthroscopy with rotator cuff repair with subocromial decompression and loose body removal.

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 shoulder arthroscopy with rotator cuff repair with subocromial decompression and loose body removal.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Fax Cover Sheet dated 9/21/07.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 9/20/07.
- Request for a Review by an Independent Review Organization dated 9/18/07.
- Determination Notification Letter dated 9/12/07, 8/2/07.
- Notice to Inc. of Case Assignment dated 9/21/07.
- Fax Cover Letter dated 9/21/07.
- Providers Utilized List (unspecified date).
- Examination Letter dated 8/29/07.
- Post-Operative Examination Note dated 7/9/07.

- **Follow-Up Examination Note dated 7/30/07.**
- **Operative Report dated 4/5/07.**
- **Left Shoulder Arthrogram/MRI dated 7/26/07.**
- **Upper Extremity Joint MRI dated 3/2/07.**
- **Left Shoulder Arthrogram dated 3/2/07.**

PATIENT CLINICAL HISTORY [SUMMARY]:

Age: xx years
Gender: Male
Date of Injury: xx/xx/xx **Mechanism of Injury:** Fall type injury.
Diagnosis: Rotator cuff (capsule) sprain.

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

This xx-year-old male was injured on xx/xx/xx after a fall on the left shoulder. The patient was subsequently taken to surgery on 4/5/07, where arthroscopy with rotator cuff repair, subacromial decompression, and loose body removal was performed by Dr. without incident. When seen on 7/9/07, Dr. noted continued shoulder pain complaints, and on physical examination pain was noted with rotator cuff testing. Impression was possible recurrent rotator cuff tear. An MR arthrogram of the left shoulder was performed on 7/26/07, which indicated “a probable small full thickness tear, mid body supraspinatus along both bursal and articular surfaces with the more anteriorly placed repair intact. More posteriorly the tendon was markedly thinned and probably there is a very small full thickness perforation. Fluid in the subdeltoid subacromial bursa was noted. Not all of which was related to contrast or extravasation does not account for the entirety and suggest bursitis of a moderate degree.” The follow-up dated 7/30/07 by Dr. noted physical examination findings of active passive motion revealing flexion 170 degrees, abduction 150 degrees, external rotational 60 degrees at the side and at 90 degrees to 90 degrees, internal rotation at 90 degrees to 50 degrees, with “L3 active IR.” There was positive Neer’s on his impingement signs. There was painful supraspinatus stress test and supraspinatus isolation test, positive Whipple’s test with negative external rotation test and negative belly press test. The 8/29/07 letter by Dr. indicated the patient attended physical therapy post-operatively, but still complained of significant pain at the 6-week follow-up. The patient continued with physical therapy and a TENS Unit until returning on 7/9/07, where the patient had continued symptoms of pain, weakness, and loss of motion. The patient was felt to not adequately heal from the first rotator cuff surgery as he continued to experience pain and weakness in the left shoulder. Dr. felt that with the most recent MRI and physical examination exhibiting a probable rotator cuff tear, the second surgery was indicated. The Official Disability Guidelines’ criteria for rotator cuff repair are recommended as indicated below. A 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 had results similar to surgical treatment, but without surgical risks. Studies evaluating results of conservative treatment of full-thickness rotator cuff tears showed 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) Revision rotator cuff repair: The results of revision rotator cuff repair are inferior to those of primary repair. While pain relief may be achieved in most patients, selection criteria should include patients with an intact deltoid origin, good-quality rotator cuff tissue, preoperative elevation above the horizontal, and only one prior procedure. (Djurasovic, 2001) The Official Disability Guidelines 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." The

rationale for full certification of this request is the patient does meet ODG criteria for full-thickness rotator cuff tear repair as the patient has subjective findings of shoulder pain and inability to elevate the arm, objective clinical findings of weakness and imaging findings on MRI for deficit in the rotator cuff.

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.
- ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.
ODG web-based 11th edition.
- 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.
