



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 08/13/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Rotator cuff repair to the left shoulder

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

Board Certified in Orthopedic Surgery

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 or not medical necessity exists for each of the health care services in dispute.

Rotator cuff repair to the left shoulder - Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A post arthrogram MRI of the left shoulder dated 05/29/08

An evaluation with M.D. dated 5/30/08
A preauthorization request form dated 06/06/08 from Dr.
A notice of non-certification from, R.N. at The dated 06/12/08
A letter from Dr. to The dated 06/13/08
Another notice of non-certification from, R.N. at The dated 06/19/08
The ODG was not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

A post arthrogram MRI of the left shoulder on xx/xx/xx revealed full thickness rotator cuff tears of the supraspinatus and infraspinatus tendons with retraction of approximately 3 to 3.5 cm and atrophy in the supraspinatus and infraspinatus and a type II acromion with spurring at the AC joint. On 05/30/08, Dr. examined the claimant and reviewed the MRI. He recommended a repair of the rotator cuff of the left shoulder. Dr. submitted a preauthorization for the left shoulder surgery on 06/06/08. On 06/12/08 and 06/19/08, the provided letters on non-certification for the requested repair of the rotator cuff of the left shoulder. On 06/13/08, Dr. addressed a letter to The regarding the denial of the left shoulder.

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

The MRI revealed evidence of a full thickness tear with retraction and atrophy of the rotator cuff muscles. The current standard of practice in orthopedic surgery is to repair the rotator cuff tears, especially when there is retraction and if they are tender. The peer reviewed literature on shoulders clearly describes that for open rotator cuff injuries, in most normal patients, that repair is the most appropriate course of care. Therefore, the requested rotator cuff repair to the left shoulder is reasonable and necessary.

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 AND KNOWLEDGE BASE
- 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)