



Notice of Independent Review Decision

DATE OF REVIEW: 7/25/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for a right shoulder arthroscopy and 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:

- X 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.

The previously denied request for right shoulder arthroscopy and rotator cuff repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Letter dated 7/21/08.
- Fax Cover Sheet/Comments dated 7/17/08, 7/16/08,
- Notice to . of Case Assignment dated 7/16/08.
- Company Request for Independent Review Organization dated 7/11/08.
- Cover Letter dated 7/16/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/14/08.
- Request Form Request for a Review by an Independent Review Organization dated 7/9/08.
- Adverse Determination after Reconsideration Notice dated 7/8/08, 2/6/08.
- Adverse Determination Notice dated 6/30/08, 1/25/08.
- SOAP Note dated 1/18/08, 12/28/07.
- Physician's Pre-Operative Orders dated 1/18/08.
- Right Shoulder X-Ray dated 12/20/07.
- Right Upper Extremity Joint MRI dated 12/20/07.
- Pre-Authorization Request Form (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age:	xx years old
Gender:	Male
Date of Injury:	xx/xx/xx
Mechanism of Injury:	Not provided for this review
Diagnosis:	Right shoulder pain on 1/18/08 and superior labral anterior posterior (SLAP) tear.

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

This xx year old male was reportedly injured on xx/xx/xx, but the method of injury was not provided in the records reviewed. Diagnoses per Dr. included right shoulder pain on 1/18/08 and SLAP tear. X-Rays of the right shoulder, completed on 12/20/07, revealed no acute fracture or dislocations, moderate degenerative acromioclavicular (AC) joint hypertrophy and no glenohumeral joint pathology. An MRI of the right shoulder, completed on 12/20/07, revealed findings suspicious for a superior labral anterior posterior (SLAP) tear or degeneration, edema in the anterior-superior aspect of the humeral head that likely represented degeneration, edema within the anterior aspect of the supraspinatus muscle that could have represented muscle strain verses a subtle muscle tear and degeneration of the AC joint. The patient participated in conservative care including physical therapy, cortisone injections, anti-inflammatories and pain medications, which did not provide relief of his symptoms. The patient underwent a right shoulder arthroscopy, rotator cuff repair, superior labral anterior posterior lesion repair,

lysis of adhesion, subacromial decompression and a distal clavicle excision on 4/17/08. As documented in Services 6/30/08 adverse determination notice, “On 05/08 the claimant was doing well six weeks post-op, however, he needed to work on strength.” and “From note on 06/08 the claimant was having problems with internal/external rotation and there was suggestion of a re-tear of the rotator cuff.” for which the surgeon requested a repeat arthroscopy to re-repair the rotator cuff. This procedure was non-certified. The surgeon recommended a right shoulder arthroscopy, rotator cuff repair. In short, there was no diagnostic testing after the reported April of 2008 procedure, and no documentation of any physical findings after the reported April of 2008 procedure to suggest that further surgery is needed. Objective physical findings plus positive pathology on imaging are noted as criteria for rotator cuff repair in the Official Disability Guidelines. Absent these critical pieces of information, the proposed surgical intervention cannot be recommended as medically necessary.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines Treatment in Worker’s Comp 2008 Updates . Shoulder – Rotator Cuff Repair.

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).