I-Decisions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: May 20, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder arthroscopy - rotator cuff repair

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)

Upon independent review the reviewer finds that the requested right shoulder arthroscopy - rotator cuff repair is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters 04/07/08, 04/11/08
ODG Guidelines and Treatment Guidelines
MRI right shoulder 03/12/08
Office notes, Dr. , 03/25/08, 04/24/08
Surgery scheduling form, 04/17/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This XX year old male claimant reportedly sustained a right shoulder injury on XX/XX/XX and was diagnosed with a right shoulder rotator cuff tear. An MRI of the right shoulder performed on 03/12/08 showed a full thickness tear present within a portion of the distal supraspinatus tendon, infraspinatus tendinosis and subacromial – subdeltoid bursitis. The records indicated that the claimant had worsening right shoulder pain with decreased range of motion and positive impingement sign. A right shoulder arthroscopic rotator cuff repair was requested.

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

I reviewed the medical records provided and the ODG guidelines. The following findings and the review of the records provided would not support medical necessity of rotator cuff repair and right shoulder arthroscopy. This is based on the fact there is no documentation of any conservative measures rendered in the form of activity modification, formal physical therapy with stretch, strength, range of motion modalities, anti-inflammatory medication, oral Medrol preparation, or a cortisone injection as a diagnostic and potentially therapeutic modality. Given the above findings and based solely on review of the records provided without the benefit of peer discussion, I cannot recommend the proposed surgery as medically indicated or necessary. This is consistent with ODG guidelines as this appears to be a partial-thickness rotator cuff as there is intact fiber surrounding the reported tear. There have not been conservative measures rendered for three to six months in the form as noted above, physical therapy, anti-inflammatories, or a cortisone injection. The claimant does demonstrate decreased range of motion, pain, and weakness.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Shoulder: Surgery for rotator cuff repair

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**
- ☐ **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)**