

CORE 400 LLC
240 Commercial Street, Suite D
Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 20, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of arthroscopy, rotator cuff repair, right shoulder.

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

MD, 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)

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 reviewer finds that medical necessity does not exist for arthroscopy, rotator cuff repair, right shoulder.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 12/3/08, 12/30/08
ODG Guidelines and Treatment Guidelines
Chiro/rehab notes, 07/23/08 to 10/23/08
Office notes, Dr. , 10/03/08, 10/06/08, 10/27/08, 11/18/08, 12/09/08
Rehab right shoulder, 10/13/08 to 10/15/08
MRI right shoulder, 11/11/08
Office notes, Dr. , 11/21/08, 12/05/08, 12/19/08
Letter, Dr. 12/01/08
Letter, 12/03/08

Letter, Dr. , 12/11/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old female who has right shoulder pain. The MRI of the right shoulder from 11/11/08 showed a chronic tear with retraction involving the supraspinatus and infraspinatus tendons with corresponding muscle atrophy. Small joint effusion and mild superior subluxation of the humeral head in relationship to the glenoid fossa was reported. Degenerative edema and cysts in the greater tuberosity of the humerus was reported. Dr. performed an injection on 12/05/08. Dr. evaluated the claimant on 12/09/08. Examination revealed tenderness right shoulder, forward flexion and abduction was to 160 degrees. Impingement sign and tenderness to the lateral shoulder was reported. The claimant has been treated with physical therapy, anti-inflammatory medications, work restrictions and injection. . The prior reviewer noted that the "shoulder MRI results clearly indicated chronic, longstanding pathology. The rotator cuff is torn, retracted and atrophied. This takes place over a period of years....None of the MRI findings would have manifested in a period of 2-3 months and none of the MRI findings are due to the occupational event of 9/10/08."

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

The 11/11/08 MRI revealed a substantial tear which was already retracted, with corresponding muscle atrophy. The reviewer does not consider the proposed surgical intervention to be medically necessary. The request does not conform to the guidelines. The reviewer finds that medical necessity does not exist for arthroscopy, rotator cuff repair, right shoulder.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, shoulder

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.

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)