

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

Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 28, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder rotator cuff repair

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 left shoulder rotator cuff repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office Visits, Dr. 1/14/08, 2/18/08,2/25/08,3/10/08,3/17/08,3/31/08, 4/7/08, 4/14/08
Emergency Room Records, xx/xx/xx
X-rays, L/S, T/S Left Humerus, Left Forearm, Right Hand, xx/xx/xx
Labwork, xx/xx/xx
First Report of Injury, 2/11/08
Lumbar MRI, 2/14/08
Notice of Disputed Issues 4/4/08, 10/28/08
Office visit Dr. 5/5/08
Office visit, Dr. 5/14/08
Office visit .Dr. 5/22/08.6/5/08,
Left Shoulder MRI, 7/30/08

Office visit Dr. 8/13/08,10/6/08
Second opinion, MRI, Dr. 8/21/08
Required Medical Evaluation, Dr. 9/3/08
Left Elbow MRI, 9/9/08
Office visit,Dr. 10/8/08,10/27/08,11/3/08,11/6/08
Pre-authorization 11/3/08, 11/26/08
Adverse Determination Letters, 11/3/08, 11/26/08
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a right hand dominant, female, employed when she went out of work on xx/xx/xx. She presented to the emergency room on xx/xx/xx after reportedly being assaulted the previous day. She complained of back, left arm and left leg pain. The diagnosis was back pain and multiple contusions to the left arm. Ibuprofen was prescribed. The claimant followed up with Dr. for continued neck and back pain. The claimant was also seen by Dr. a psychologist who had treated the claimant in the past for post traumatic stress disorder since 1977. The claimant treated with medications and therapy with ongoing complaints.

Dr. orthopedic, saw the claimant on 05/22/08, diagnosed cervical, thoracic and lumbar pain, and left arm pain. On 07/30/08, left shoulder MRI reported mild tendinosis within the supraspinatus distal tendon with a partial thickness articular surface tear, moderate acromioclavicular joint arthrosis and a small glenohumeral joint effusion. Examination of the left shoulder on 08/13/08 noted tenderness at the AC joint and medial scapular area with negative impingement testing. There was tenderness along the distal biceps tendon. The impression was possible AC joint arthritis, left scapular trigger point, left biceps tendinopathy and possible partial biceps avulsion of the radial tuberosity. A cortisone injection to the left AC joint on 08/13/08 provided immediate relief.

On 08/21/08, the left shoulder MRI was re-reviewed. The radiologist noted moderate supraspinatus tendinosis more prominent along the undersurface anteriorly with at most minimal undersurface fibrillation without high grade partial or full thickness tear.

Dr. orthopedics, saw the claimant on 10/08/08. The clamant reported no tenderness over the biceps tendon and Dr. reviewed the shoulder MRI and was unimpressed. He released the claimant to full time duty. The same date, Dr. saw the claimant. Left shoulder abduction was to 150 degrees, external rotation to 60 and internal rotation to 30. Impingement testing was positive and left shoulder rotator cuff repair was recommended.

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

This patient has had pain since xx/xxxx when she was assaulted, although the medical record documents different areas of complaints on different days. There is also documentation of changing physical findings and no evidence on the MRI of a full thickness rotator cuff tear. It is not clear as to whether full conservative care has been performed as there is no documentation of a left shoulder subacromial injection. ODG guidelines document the use of rotator cuff repair in patients who have significant partial thickness tear and have failed three to six months of conservative care to include physical therapy, home exercises, and an injection as well as have positive physical

findings of weakness and limitation in function. In light of the fact that this patient has changing physical findings and an MRI without evidence of high grade rotator cuff abnormality and the fact that she has not had a complete conservative care program to include an injection, the reviewer finds the requested rotator cuff repair is not medically necessary. The request does not meet the guidelines. The reviewer finds that medical necessity does not exist for left shoulder rotator cuff repair.

Official Disability Guidelines Treatment in Worker's Comp, 2009 Official Disability Guidelines, 14th edition, Shoulder

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.

[\(Washington, 2002\)](#)

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)