



Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 7/22/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for right shoulder rotator cuff repair with acromioplasty (ACR).

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:

- 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 rotator cuff repair with ACR.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Texas Department of Insurance Fax Cover Sheet dated 7/10/09.
- Patient Information Sheet (unspecified date).
- Certification of Independence of the Reviewer Sheet (unspecified date).
- Request for IRO/Letter dated 7/14/09.
- Notice to Inc. of Case Assignment Sheet dated 7/10/09.
- Medical Documentation Attachment/Letter dated 7/10/09.
- Confirmation of Receipt of a request for a Review by an Independent Review Organization (IRO) Form dated 7/8/09.
- Request for/Request for a Review by an Independent Review Organization Form dated 6/30/09.
- Adverse Determination after Reconciliation Notice dated 5/29/09, 5/15/09.
- Doctor's Note dated 5/22/09.
- Diagnosis note dated 6/16/09, 5/23/09, 5/11/09, 4/13/09, 3/9/09.
- Insurance Verification Form dated 2/3/09.
- Patient Information Sheet dated 2/3/09.
- MRI of the Right Shoulder Report dated 1/21/09.
- Determination of Patient satisfaction with outcome after shoulder arthroscopy article (unspecified date).
- Massive Irreplaceable tears of the rotator cuff article (unspecified date).
- Arthroscopic surgery compared with supervised exercises in patient with rotator cuff disease article (unspecified date).
- Washington State Department of Labor and Industries guidelines (unspecified date).
- Integrated Treatment/Disability Duration Guidelines (unspecified date).
- X-Ray Note (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years

Gender: xxx

Date of Injury: xx/xx/xx

Mechanism of Injury: Repetitively pushing a steel cart weighing 125 pounds.

Diagnosis: Right rotator cuff tear

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

The patient is a xx-year-old male with the date of original injury xx/xx/xx. The mechanism of injury pushing a steel cart repetitively weighing 125 pounds. Subsequently, the patient underwent an MRI on January 21, 2009, that noted high-grade partial thickness intrasubstance tearing with inability to entirely exclude full thickness involvement and there was also a suspected distal infraspinatus partial tear without full thickness tear. The subscapularis had moderate to advanced tendinopathy with abnormal partial thickness tearing. The biceps tendon was subluxed with intrasubstance signal abnormality compatible with tendinopathy. There was moderate acromioclavicular hypertrophy arthropathy with type 2 acromion with reactive and/or subchondral cyst changes. Examination done on 2/3/09 revealed decreased abduction and decrease internal rotation. There was subacromial tenderness and a weak grip. According to medical records provided for review, the patient subsequently went to surgery on March 4, 2009, where rotator cuff repair and acromioplasty was performed. As of May 11, 2009, the handwritten note indicated the patient was doing great, had less pain, good range of motion, was weak, and was going to occupational therapy (OT). In a note of May 22, 2009, in review of the denial, Dr. stated the reason for denial of the request for the surgery was lack of significant physical examination findings. Dr. stated on MRI, the right shoulder clearly stated partial tear with the inability to exclude a full thickness tear. He did not believe physical therapy would improve the patient's condition. The rationale for recommending non-certification of the requested procedure was based on the Official Disability Guidelines criteria for rotator cuff repair with acromioplasty. Per ODG there should be 3 to 6 months of conservative treatment prior to surgery. Such a treatment program may have averted the need for surgery. The reviewed medical record did not document a trial of conservative care and therefore the criteria for surgery was not satisfied.

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.
- 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).