



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 3/25/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The service under dispute is a rotator cuff repair, subacromial decompression, right shoulder with Marcaine with epinephrine for interoperative control of hemostasis not as a nerve block.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery and has been practicing for greater than 15 years.

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)

The reviewer agrees with the previous adverse determination regarding all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Patient, and Dr.

These records consist of the following (duplicate records are only listed from one source): Patient: 2/21/08 and 10/28/08 reports by, DC, 4/28/08 report by DC, 9/29/08 report by Dr., 12/11/08 left shoulder MRI report and 1/8/09 and 1/26/09 reports by Dr.

Dr.: 2/6/09 peer to peer report.

: 3/9/09 letter by, 1/22/09 and 2/10/09 denial letters, 3/9/09 IRO summary letter, DWC form 1, associate statement for WC dated 2/12/08, 2/19/08 pln 11, 4/10/08 pln-1, request for leave of absence form, 2/12/08 handwritten script and note by,

MD, various DWC 73 reports, handwritten office notes by Chiropractic and Rehabilitation from 2/21/08 to 12/1/08, various DWC form 6, 4/8/08 report by, DO, 4/23/08 dispute of medical records review, CCH report of 7/21/08, 6/17/08 RME by, MD, 10/27/08 appeals panel report, rehab notes 11/17/08 to 12/1/08, 12/29/08 report by, MD, 1/21/09 radiology report, 1/21/09 EKG report, 1/21/09 lab panel report, 1/26/09 surgery orders, 1/28/09 report by Dr. and 2/2/09 preauth request.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case concerns a male who injured the left shoulder on xx/xx/xx when unloading truck at work. The patient was treated with therapy modalities, massage and manipulations ordered or performed by Dr. He was seen by Dr for RME 06/18/2008, and was found to have a full range of active and passive motion and full strength. He was sent for MMI by TDI to Dr and found not to be at MMI. The MRI done 12/11/08 revealed partial thickness tears subscapularis and supraspinatus with slight biceps tendonitis and AC DJD with impingement. There is no evidence in the records provided of diagnostic subacromial injection relieving pain, atrophy or abduction weakness.

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

There is no evidence or note of subacromial injection relieving pain and no weak or absent abduction that has been persistent (patient was noted to have full strength in 6/18/08 RME which he would not have had with a cuff tear originating 2/18/08). The ODG criteria for the requested procedures are as follows:

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. (this criterion is met) 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). (This criterion is NOT met) 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. (this criteria is met)

Due to all of the required criteria not being met, the requested service is not medically necessary at this time.

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)