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**Amended Report of 12/1/09  
Notice of Independent Review Decision**

**DATE OF REVIEW:** 11/25/09

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The items in dispute are the prospective medical necessity of right shoulder subacromial decompression, right shoulder Marcaine injection w/ Epinephrine for interoperative control of hemostasis, and right shoulder rotator cuff repair (29827, 29826, 23700, 23823, 64417, E0218NU and E0935).

**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. This physician has been practicing for greater than 15 years and performs this type of procedure in daily practice.

**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 the prospective medical necessity of right shoulder subacromial decompression, right shoulder Marcaine injection w/ Epinephrine for interoperative control of hemostasis, and right shoulder rotator cuff repair (29827, 29826, 23700, 23823, 64417, E0218NU and E0935).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Services and MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Services: email – 9/18/09; MD Pre-Cert request – 9/18/09(x2), Appeal Request – 10/13/09, Office Notes – 8/14/09-9/30/09; HNRA MRI report – 8/20/08; email – 9/23/09 & 10/20/09; AMR Physician Reviewer Report – 9/23/09 & 10/20/09; Xchanging Denial Letter – 9/23/09 & 10/20/09; email – 10/14/09; Tomography report – 8/14/08. Records reviewed from MD: Medical Centers Progress Notes – 9/10/08-10/19/09, Initial Medical Report – 8/22/08, Subsequent Medical Report – 9/29/08, Reconsideration Request – 11/20/08, Prescription – 1/8/09-10/5/09, Follow-up WC Visit Notes & Treatment Plan – 10/23/08-10/5/09, Detailed billing – 6/8/09; MD Follow-up Report – 8/13/09; Management Center PT/OT Plan of Care – 3/26/09; MD Office Notes – 1/27/09-8/25/09; Mental Health Eval Initial Eval – 3/31/09, Team Treatment Plan – 3/31/09.

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This case involves a female who had been injured at work when she slipped and fell. This fall led to a closed head injury, cervical herniated disc and shoulder strain. The patient underwent physical therapy and one set of three trigger point injections with no benefit. An MRI of the shoulder dated 8/20/08 revealed impingement and supraspinatus tendonitis.

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

This patient has no documented subacromial injection, has no documented cervical disc herniation treatment, and has no test showing rotator cuff tear. The ODG criteria for surgical repair of a rotator cuff are clear and listed below. Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:

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)**