

# MEDR X

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 11/12/2009

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of right shoulder RCR, SAD, Acromioplasty, rotator cuff debridement / bicep tenodesis.

**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. The reviewer refers for this type of examination on a frequent basis and has been practicing for greater than 10 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 disagrees with the previous adverse determination regarding the prospective medical necessity of right shoulder RCR, SAD, Acromioplasty, rotator cuff debridement / bicep tenodesis.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
and Orthopaedic Group

These records consist of the following (duplicate records are only listed from one source):  
Records reviewed Orthopaedic Group Pre-authorization request – 8/26/09 and  
Reconsideration request – 9/21/09; Medical Centers Patient Referral – 7/1/09; MD  
Transcription – 8/20/09; MD MRI report – 6/29/09.  
Records reviewed from Orthopaedic Group: MD Encounter Summary – 8/25/09-10/16/09;  
OT Transcription – 8/18/09; OTR Transcription – 7/16/09-8/11/09.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who was injured on xx/xx/xx. The patient was undergone 3 months of physical therapy and exercises. He has failed to improve. He received 2 injections and had relief with the first but only days of relief with the second. The patient has persistent pain and weakness. An MRI reveals intrasubstance tear of rotator cuff, anteriorly hooked acromion, and torn glenoid labrum.

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

The ODG Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair is:

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent, 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

The patient has had an adequate 3 month course of physical therapy, injections and is worsening with pain and weakness to abduction and positive impingement signs. An MRI reveals rotator cuff tear. The patient has met the ODG criterion; therefore, this procedure is medically necessary.

**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 KNOWLEDGBASE
- 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)