



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 11/5/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of Arthroscopic Right Shoulder Rotator Cuff Repair, Biceps Tenodesis, Subacromial Decompression, and Coplane (29827, 29828, 29826, 29824).

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 Arthroscopic Right Shoulder Rotator Cuff Repair, Biceps Tenodesis, Subacromial Decompression, and Coplane (29827, 29828, 29826, 29824).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD: Pre-authorization Request – 9/22/09, Appeal Letter – 9/29/09, Ultrasound Report – 9/11/09, Patient Assessment – 9/11/09; MD report – 2/12/09; DC SOAP Notes – 2/9/09; Chiropractic Health Initial Exam – 2/9/09; Notice of Disputed Issue – 9/30/09.

Records reviewed from Group: Denial Letter – 9/29/09 & 10/9/09; IRO Summary – 10/20/09; DWC1 – 12/8/07; Notice of Disputed Issue – 12/28/07-8/1/09; Request for Leave of Absence – 1/10/08; DO report – 12/18/07-1/7/08; TWCC6 – 12/18/07-7/24/09; PT report – 1/4/08, Daily Progress Note – 1/4/08-1/9/08; Physical Performance Test – 12/18/07; MD MRI Report – 12/19/07; MD report – 12/20/07; MD WC Eval – 1/10/08, Office Notes – 1/31/08-2/21/08, Shoulder Examination – 1/16/08 Cervical Examination – 6/23/08, PT Notes – 1/16/08-7/8/08; MD Operative Report – 2/27/08, Office Notes – 3/3/08-1/16/09; Hospital Stay Records – 2/21/07-2/27/08; letter – undated; MRI report – 8/22/08; MD letter – 10/21/08; DC SOAP Notes – 7/6/09; MD Follow-up Shoulder MRI Eval – 9/22/09, MRI Report – 9/22/09; MD report – 9/25/09.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee is a female. She injured her right shoulder at work and underwent right shoulder arthroscopy for partial thickness rotator cuff tear (RCT) and had this debrided. She initially improved, but now complains of shoulder pain and weakness.

A recent workup shows high grade partial thickness or possibly small full thickness RCT.

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

According to the ODG, debridement of partial thickness rotator cuff tear is not always a permanent and final cure. As per study by SC Weber (Arthroscopy 1999), 32 patients with significant partial-thickness rotator cuff tears were treated with debridement and acromioplasty versus 33 patients who were with mini-open repair.

In the acromioplasty and debridement group,

- 3 patients re-ruptured the remaining cuff later;
- healing of the partial tear was never observed at second-look arthroscopy;
- the good results of arthroscopic treatment of significant partial-thickness tears deteriorated with time;

The patient meets ODG Criteria for Rotator cuff repair and revision rotator cuff tear repair; 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 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)