



Notice of Independent Review Decision
IRO REVIEWER REPORT

DATE OF REVIEW: 8/2/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for outpatient right shoulder surgery including arthroscopic rotator cuff repair, open repair ruptured musculotendinous cuff, subacromial decompression, acromioplasty, debridement, and tenodesis of long tendon of biceps.

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:

- X 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 outpatient right shoulder surgery including arthroscopic rotator cuff repair, open repair ruptured musculotendinous cuff, subacromial decompression, acromioplasty, debridement, and tenodesis of long tendon of biceps.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice to CompPartners, Inc. of Case Assignment dated 7/23/10.
- Request for a Review By an Independent Review Organization dated 7/22/10.
- Request Form dated 7/21/10.
- Notice of Utilization Review Findings dated 7/15/10, 6/25/10.
- Billing Letter dated 7/15/10, 6/25/10.
- Pre-Authorization Letter dated 7/26/10.
- Employee's Report of Injury dated 12/8/09.
- Notice of Disputed Issue dated 5/6/10, 3/10/10, 1/28/10.
- Request Form dated 6/21/10.
- Right Shoulder MRI dated 1/4/10.
- Cervical Spine MRI dated 4/27/10.
- Evaluation Report dated 6/29/10, 5/25/10, 3/12/10, 2/11/10, 1/12/10, 1/5/10.

- Designated Doctor Evaluation dated 4/21/10.
- Physical Examination Report dated 4/1/10.
- Authorization Request dated 6/21/10.
- History/Physical Examination dated 6/29/10, 5/25/10, 2/25/10, 2/11/10.
- Request for Designated Doctor dated 12/4/09.
- Diagnostic Tests dated 3/12/10.
- Chart Note dated 5/7/10.
- Patient Registration Form dated 12/1/09.
- Physical Daily Progress Notes dated 2/2/10, 2/1/10, 1/26/10, 1/25/10, 1/22/10, 1/20/10.
- There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: The claimant was breaking and shoveling ice when he slipped and fell forward.

Diagnosis: 726.10, rotator cuff syndrome NOS; 840.6, sprain supraspinatus; 719.41, joint pain shoulder

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

This male sustained a work-related injury to his right shoulder on xx/xx/xx. The claimant was breaking and shoveling ice when he slipped and fell forward. He broke his fall with the shovel and developed sharp pain in his right shoulder. An MRI of his right shoulder on 01/04/10 showed tendinosis of the supraspinatus, infraspinatus, and subscapularis tendons without a full thickness rotator cuff tear; mild tenosynovitis of the long head of the biceps tendon; a small subacromial spur with small subacromial subdeltoid bursitis; and a small posterior superior labral tear. The claimant was treated conservatively with physical therapy, injections, medications, and rest with no improvement in his symptoms. The claimant underwent a medical evaluation by Dr. on 04/01/10 and he felt that the claimant's work-related injury should have resolved itself after 8 weeks and the claimant was not a surgical candidate. The claimant also had a designated doctor's evaluation with Dr. on 04/21/10. When the claimant saw Dr. on 05/25/10, he had mild pain on cross arm abduction. His external rotation on the right was equal to the left and internal rotation was to L4-5. He had good strength with his right arm at his side, but had pain and weakness on abduction. He had a mild Speed's and Yergason's at the greater tuberosity. Dr. recommended surgery. This has been denied twice and Dr. requested an appeal. Based solely on review of the records provided and evidence-based medicine, and without the benefit of peer discussion, this reviewer cannot recommend the proposed surgery as medically indicated and appropriate at this time.

Per the ODG, criteria for rotator cuff repair or anterior acromioplasty with diagnosis of partial thickness rotator cuff repair or acromial impingement syndrome is 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 range of motion, 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, anterior posterior, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.”

Evidently Yergason’s test was negative previously. The MRI showed only tendonitis. It is unclear if the claimant had a cortisone injection within the bicipital groove as a diagnostic potentially therapeutic modality. It is unclear if the claimant had subacromial injections or glenohumeral injections. It is unclear that the claimant has exhausted physical therapy, stretching, range of motion, medications. Given the issues in this case, it might be reasonable to obtain an MR arthrogram to give more information. As such, the proposed procedures (right shoulder scope, rotator cuff repair and debridement, decompression, and biceps tenodesis) would not be considered medically necessary given the lack of information on other treatments. Therefore, the previous adverse determination is upheld.

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.

Shoulder-rotator cuff surgery

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).