

Becket Systems

An Independent Review Organization
13492 Research Blvd. Suite 120-262
Austin, TX 78750-2254
Phone: (512) 553-0533
Fax: (207) 470-1075
Email: manager@becketsystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/03/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

23410 Open Left Shoulder Rotator Cuff Repair;
29827 Arthroscopic Left Shoulder Rotator Cuff Repair

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

MD Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

This is a -year-old female with complaints of left shoulder pain. The claimant reported that a box from a shelf fell and struck her head and neck on xx/xx/xx. The claimant began treating with for chiropractic care on 09/21/09. The cervical spine x-rays from 09/23/09 showed significant narrowing of the disc space between C5 and C6. It was noted that an injury to the disc space in between could not be totally excluded by plain films and MRI was needed to evaluate the disc space.

There was straightening of the cervical spine probably secondary to muscle spasm. C7 was not clearly seen secondary to body habitus. No fracture or dislocation at C1-C6 was reported. The MRI of the cervical spine from 10/06/09 showed straightening of the cervical lordosis with muscle spasm or strain. Disc pathology was identified at each of the C3-4, C4-5, C5-6 and C6-7 levels. On 10/08/09, evaluated the claimant for neck and left shoulder pain. Cervical range of motion was restricted and painful. There was pain with left shoulder flexion, abduction, and adduction. There were multiple palpable trigger points to the neck and shoulder. Diagnosis was neck pain with radicular symptoms, myofascial pain, thoracic pain and headaches. Recommendations were for trigger point injections, cervical epidural steroid injection and physical therapy. The MRI of the left shoulder from 10/15/09 showed a full focal full thickness tear of the distal supraspinatus tendon. Minimal fluid was seen extending into

the region of the subacromial and subdeltoid bursa. No fracture, subluxation or dislocation was present in the left shoulder. Curved type II acromion with normal slope was noted. The 01/11/10 electromyography showed carpal tunnel syndrome and no cervical radiculopathy. evaluated the claimant on 02/04/10. Positive Neer and Hawkins was noted. has recommended a rotator cuff repair. The claimant has been treated with Flexeril, Anaprox, work restrictions, home exercise program, therapy and trigger point injection to the left shoulder.

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

An MRI demonstrates on 10/15/09 a full thickness tear of the distal supraspinatus tendon. There are documented subjective complaints of left shoulder pain and dysfunction. Objectively, there are impingement signs and weakness of the rotator cuff throughout the medical records. Based upon the subjective complaints and objective findings substantiated by an MRI, the request meets ODG criteria for rotator cuff repair surgery. The rotator cuff has no intrinsic capability to repair itself. The reviewer finds that medical necessity exists for 23410 Open Left Shoulder Rotator Cuff Repair; 29827 Arthroscopic Left Shoulder Rotator Cuff Repair.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter shoulder, rotator cuff repair

ODG Indications for Surgery | -- Rotator cuff repair

Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out

1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS

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-AMERICA 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)