

Notice of Independent Review Decision

DATE OF REVIEW: 9/9/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for right shoulder rotator cuff repair

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

The physician providing this review is Board Certified Orthopedic Surgeon. He has received honors and awards for his research and is a published writer of professional literature and abstracts as well as contributions to texts books. He has been in private practice since 2001. He is licensed in the state of Texas.

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)

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.

Based upon review of the medical records, I cannot recommend the proposed surgery as medically necessary and indicated at this time.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records received: 14 page fax 8/27/2010 Texas Department of Insurance IRO Request, 40 page fax 9/1/2010, from URA documents included: IRO Request form from the patient, IRO assignment by TDI, Request for IRO from URA – TDI, Initial denial documents, Appeal denial documents, Other medical reports/documents

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male who was status post xx/xx/xx right shoulder subacromial decompression, debridement of labral tear and of partial rotator cuff tear. Postoperatively, the claimant underwent physical therapy. The MR arthrogram of the right shoulder, 05/03/10, revealed a complex full thickness tear of the supraspinatus tendon, possible SLAP tear, and acromioclavicular mild arthritis. On 06/07/10, the claimant underwent a right subacromial joint injection for mild relief. Dr. saw the claimant on 07/12/10 for complaints of right shoulder pain and weakness. Dr. stated that the claimant was seen last month and was given another injection which provided minimal relief due to pain and

weakness. The claimant was taking Lortab. Dr. saw the claimant on 08/03/10. Examination revealed mild crepitus, forward flexion to 90 degrees, abduction to 70 degrees and external rotation strength of 5/5.

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

A review of the records provided supports claimant is a male status post right shoulder subacromial decompression debridement on xx/xx/xx. The claimant was treated post operatively with physical therapy. The MRI on 05/03/10 showed a complex full thickness tear of the supraspinatus tendon. Dr. evaluated the claimant on 05/10/10 and noted tenderness, restricted range of motion. The claimant was given a cortisone injection on 06/07/10, subacromial space, which gave mild relief of symptom and recommended repair. The claimant was treated with Lortab and off work. Evidently the claimant had a DDE schedule for 08/13/10; those records are not available for review.

Based upon review of the medical records, this reviewer cannot recommend the proposed surgery as medically necessary and indicated at this time. Complete documentation of the DDE that was performed on 08/13/10 is not provided. Evidently the claimant underwent a scope debridement without complication on 01/13/10, but the operative note is not available for review. It does appear the claimant was treated with a cortisone injection, pain medications and it is unclear if they tried anti-inflammatory medications or physical therapy. It is not clear if cervical pathology has been ruled. Given the above issues, the proposed surgery is not supported as medically necessary at this time.

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.

American College Of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Second Edition, (2004), chapter 9, page 210 to 211

Red-flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc

Activity limitation for more than four months, plus existence of a surgical lesion

Failure to increase ROM and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion

Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair

Rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months.

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 -- SEE REVIEW ABOVE
- 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)