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Notice of Independent Review Decision

Amended Report of 8/3/11

DATE OF REVIEW: 8/1/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a left shoulder rotator cuff repair and acromioplasty (23410, 23130).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Doctor of Osteopathy who is board certified in Orthopedic Surgery. The reviewer 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 agrees with the previous adverse determination regarding the prospective medical necessity of a left shoulder rotator cuff repair and acromioplasty (23410, 23130).

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties: and Dr.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 6/16/11 denial letter, 6/29/11 denial letter, 6/7/11 referral form, 6/7/11 handwritten exam note, 5/24/11 left shoulder MRI report, undated patient demographics form, 5/17/11 exam form, Therapy notes 5/18/11, 5/14/11 ED notes and a DWC form 1 undated.

Dr.: 6/12/11 handwritten office note.

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

PATIENT CLINICAL HISTORY [SUMMARY]:
This male was injured xx/xx/xx as noted in the first report of injury from pushing and offloading irregular items from a dolly. The May 24, 2011 MRI and noted supraspinatus mild tendinosis and partial thickness tear with mild infraspinatus tendinosis and then intra-substance split. Mild/moderate subscapularis tendinosis with longitudinal split tearing and mild tendinosis of the long head of the biceps with mild tenosynovitis was noted. Small effusion in the subscapularis recess was noted. The prior reviewed and noted medical report June 7, 2011 stating patient wearing a left shoulder immobilizer with continued pain and symptoms. Decreased range of motion in abduction and internal rotation was identified and the patient was noted to claim he cannot sleep on the left side. Rotator cuff repair acromioplasty was requested.

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

The medical records do not document a history of 3 months continuous or 6 months intermittent rehabilitation as required by ODG criteria listed above. According to the records reviewed the injured worker does not meet the criteria to have the requested procedure performed at this time. Therefore, it is found to be not medically necessary at this time.

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)**