

Notice of Independent Review Decision

**REVIEWER'S REPORT**

**DATE OF REVIEW:** June 6, 2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Arthroscopy, shoulder, w/rotator cuff repair.

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

Doctor of Medicine (M.D.), Board Certified in Orthopaedic Surgery

**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)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
840.4	23420		Prosp.						Overturn
840.4	29827		Prosp.						Overturn
840.4	L3670		Prosp.						Overturn

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Certification of independence of the reviewer and case assignment
2. Case assignment
3. Letters of denial 4/16/10, 1/12/11, and 1/13/11, including criteria used in the denial.
4. Initial evaluation – chiropractic 11/01/10.

5. Operative report 5/28/10. Follow up 11/05/10.
6. Designated doctor exam 8/31/10
7. Outpatient office notes 06/30/10 – 10/27/10 (10 visits)
8. Lab reports 04/26/10. Radiology reports 1/05/10, 04/26/10, & 11/18/10.
9. IRO reports 12/22/10 & 01/13/10

**INJURED EMPLOYEE CLINICAL HISTORY:**

The patient is over 6 months status post rotator cuff repair and subacromial decompression. CTarthrogram has confirmed a recurrent full thickness tear of the supraspinatus. The insurance company has denied repeat surgery because the imaging does not demonstrate impingement.

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

The medical records demonstrate recurrent tear or inadequate healing of the cuff tear. The request for repeat tear with subacromial decompression is medically reasonable and appropriate. Impingement does not need to be demonstrated for this case scenario, as a subacromial debridement is almost always performed in association with a rotator cuff repair. The request is medically reasonable and appropriate.

**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 GUIDELINESIEW.
- 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