

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder rotator cuff repair 23410

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

M.D., Board Certified Orthopedic 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG-TWC

Notifications of adverse determination 10/21/11, 09/27/11

Initial evaluation and progress notes Dr. 10/12/11-10/20/11

Procedure reports right sided stellate ganglion block 08/16/11, 02/22/11, and 01/04/11

MRI right shoulder 02/10/11

Right shoulder MRI arthrogram 09/20/11

Office notes Dr. 04/05/10-10/03/11

Operative report 04/22/10 right shoulder arthroscopy

Designated doctor evaluation Dr. 07/29/11

Operative report 03/29/11 right shoulder examination under anesthesia, arthroscopy

Physical therapy evaluation and notes 03/31/11-05/24/11

Follow-up reports Ph.D. and M.D. 09/11/10-01/08/11

EMG/NCV results 08/06/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who was injured onxx/xx/xx when he fell into a hole to his waist, hit a pallet with his right arm, injuring his right elbow and pushing his right arm upwards. He underwent right shoulder rotator cuff repair with distal clavicle resection on 04/22/10, and status post repair right shoulder glenoid labrum tear 03/29/11. She underwent stellate ganglion block on right side x 3 for right upper extremity pain, swelling, allodynia, and mottled appearance to right shoulder. The patient continued to complain of right shoulder pain. MR arthrogram of the right shoulder on 09/20/11 revealed a tiny tear in rotator cuff at superior aspect of humeral head located near junction of supraspinatus and infraspinatus tendons, with remainder of rotator cuff appearing intact, and no evidence of labral tear. The claimant was seen by Dr. on 09/21/11 for review of right shoulder after surgery on 03/29/11 with arthroscopy and repair of glenoid labrum tear. It was noted the claimant has had nerve block

with Dr. and has been through a work-conditioning program. MRI arthrogram was reviewed. Physical examination showed the claimant continued to have good range of motion and can easily raise arm overhead. Weakness was noted. He can place his hand behind his back and behind his head. He can touch the opposite shoulder. He complains of pain in extremes of motion. There seems to be component of impingement with elevating his arm above shoulder level. The claimant was recommended to undergo rotator cuff repair.

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

Per ODG guidelines, criteria for partial thickness rotator cuff repair include 3-6 months of conservative treatment including stretching and strengthening to balance musculature, pain with active arc motion 90-130 degrees and pain at night, and weak or absent adduction and tenderness over rotator cuff or anterior acromial area and positive impingement sign with temporary relief of pain with anesthetic injection (diagnostic injection test), and positive evidence of deficit of rotator cuff in imaging. The patient reportedly has had physical therapy following most recent right shoulder surgery, and documentation indicates the claimant had completed 14 visits of therapy from 03/31/11-05/24/11. However, there is no indication diagnostic injection was performed. As such, the reviewer finds medical necessity is not established for Right Shoulder rotator cuff repair 23410.

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)