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Notice of Independent Review Decision

DATE OF REVIEW: 11/03/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder arthroscopy, subacromial decompression, rotator cuff revision, arthrotomy, and allograft

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X 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.

Left shoulder arthroscopy, subacromial decompression, rotator cuff revision, arthrotomy, and allograft - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A DWC Form 32 dated 04/02/09
An MRI of the left shoulder dated 05/04/09 and interpreted by, M.D.
Patient referrals dated 05/05/09 and 01/27/10
Letters from M.D. dated 05/14/09 and 10/01/09 addressed to Dr.
Evaluations with M.D. dated 05/14/09, 06/26/09, 07/09/09, 07/30/09, 08/27/09, 10/01/09, 11/02/09, 11/30/09, and 01/25/10
An operative report from Dr. dated 06/24/09
Physical therapy notes from dated 07/29/09, 08/26/09, 10/29/09, 11/17/09,
MRIs of the left shoulder and left humerus dated 01/27/10 and interpreted by Dr.
A Patient Information sheet dated 03/22/10
An evaluation dated 05/10/10 with an unknown provider (no name or signature was available)
A letter of referral dated 05/17/10 from D.C.
An EES-14 dated 05/19/10
Evaluations with M.D. dated 05/28/10, 06/18/10, 07/22/10, 08/25/10, 09/29/10, 11/10/10, and 01/12/11
A Designated Doctor Evaluation dated 06/03/10 from M.D.
A DWC-69 form from Dr. dated 06/03/10
A HICFA form 1500 dated 06/03/10
A left shoulder arthrogram dated 01/04/11 and interpreted by, M.D.
A preauthorization request from Dr. dated 01/14/11
An operative report from Dr. dated 01/31/11
Evaluations with Dr. dated 02/08/11, 04/07/11, and 08/18/11
Fax requests for preauthorization dated 02/09/11 and 04/14/11 from Dr.
A letter for referral from Dr. dated 08/19/11
A letter from M.D. addressed to Dr. dated 08/25/11
Evaluations with M.D. dated 08/25/11 and 09/26/11
A request for treatment authorization form dated 09/08/11 from Dr.
A review determination from M.D. with dated 09/13/11
A Notice of Determination dated 09/13/11 from Dr.
A fax request for appeal dated 09/29/11 from Orthopaedic Surgery Group
A letter dated 09/29/11 addressed to Dr. noting the appeal had been received on 09/29/11

Another Notice of Determination dated 10/06/11 from M.D.
The Official Disability Guidelines (ODG), Chapter on the Shoulder, were provided for review

PATIENT CLINICAL HISTORY

An MRI of the left shoulder on 05/04/09 revealed a large retracted tear of the supraspinatus tendon proximal to the insertion superior facet greater tuberosity with the retracted segment extending to the midhumeral head without atrophy of the muscle. A moderated sized non-retracted tear of the infraspinatus tendon at the myotendinous junction was noted with findings suggestive of an acute to

subacute process. Degenerative changes of the AC joint with os acromiale or old posttraumatic were found. On 05/14/09, Dr. recommended a rotator cuff repair of the left shoulder, which was undertaken on 06/24/09. The patient attended physical therapy on 07/29/09, 08/26/09, 10/29/09, and 11/17/09. On 08/27/09, Dr. prescribed nine more sessions of therapy, as the patient had missed sessions because he had been out of town for a funeral. Lortab and Motrin were prescribed. Dr. performed a left subacromial space steroid injection on 01/25/10 because a couple of weeks prior at work he began experiencing pain to the left shoulder. MRIs of the left shoulder and left humerus were performed on 01/27/10. The MRI of the shoulder revealed findings suggestive of avulsion of the long head of the biceps tendon. There was no evidence of a rotator cuff tear and degenerative changes of the AC joint were noted. The MRI of the humerus revealed a complete tear of the long head of the biceps tendon superior glenoid labrum with the retracted segment retracted 8 cm. distally to the humeral head. Dr. performed a Designated Doctor Evaluation on 06/03/10. He felt the patient had reached Maximum Medical Improvement (MMI) on 06/03/10 and assigned him a 6% whole person impairment rating. Dr. recommended another MRI of the left shoulder on 06/18/10. On 09/29/10, the patient noted he had pain at night and could not lift the arm and he had limited range of motion. Dr. recommended an MRI arthrogram, which was performed on 01/04/11 and revealed findings compatible with a full thickness rotator cuff tear. Dr. performed comprehensive diagnostic arthroscopy, arthroscopic subacromial decompression, release of the coracoacromial ligament, and mini arthrotomy with rotator cuff repair on 01/31/11. On 04/07/11, Dr. recommended six sessions of postoperative therapy. Dr. evaluated the patient on 08/25/11 and the risks and benefits of surgery, including the allograft and graft jacket, were discussed and the patient wanted to proceed. X-rays performed that day showed some superior migration of the head. The swivel lock type of anchors were not seen as they were used from the last repair. On 09/13/11, Dr. provided a non-certification for the requested left shoulder arthroscopy, subacromial decompression, rotator cuff repair revision, arthrotomy, and allograft. ESIS provided another non-certification for the requested left shoulder arthroscopy, subacromial decompression, rotator cuff repair revision, arthrotomy, and allograft on 10/06/11 from Dr..

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

This patient has had two separate rotator cuff repairs done surgically. The first was on 06/24/09 and the second was in 01/31/11. Despite two appropriately and adequately performed surgeries, the patient continues to have shoulder pain. The treating physician is requesting another rotator cuff repair with an allograft jacket. There is no evidence in the peer reviewed literature that a third procedure using the graft jacket would substantially reduce this patient's pain. This patient has already failed two previously done surgeries that were performed appropriately and continued to have pain despite appropriate treatment. There is limited evidence that just covering the hole with the graft jacket would substantially improve the patient's pain. On the 08/25/11, the patient had no

atrophy or winging. Active range of motion was 90 degrees and passively, he could get to 160 degrees. On 09/26/11, the left shoulder again showed no atrophy or winging. He had painful limited active range of motion and good passive range of motion. It was noted this examination was unchanged from the 08/25/11 one with marked weakness and crepitus. The 08/25/11 evaluation does not state whether there was a positive impingement sign or tenderness over the rotator cuff or anterior acromial area. The 09/26/11 evaluation does not state whether there was an impingement sign and only states tenderness over the greater tuberosity and AC joint. Furthermore, as Dr. points out in this note, there is no guarantee for a favorable outcome and they might not be able to repair the rotator cuff. It also does not appear, based on the documentation provide, he has exhausted conservative treatment including appropriate postoperative therapy and injections. Therefore, the requested left shoulder arthroscopy, subacromial decompression, rotator cuff revision, arthrotomy, and allograft is not reasonable or necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE**
- ☐ **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**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **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)**