

SENT VIA EMAIL OR FAX ON  
Oct/27/2011

## Independent Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Oct/26/2011

**IRO CASE #:**

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

O/P Right shoulder with RTC and Subacromial Decompression

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

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**

OD Guidelines

Notification of reconsideration determination dated 08/23/11

Non-certifying appeal request O/P, right shoulder with RTC and subacromial decompression

Worker's Compensation pre-certification request and reconsideration request forms

New patient evaluation MD, dated 07/19/11

MRI of the right shoulder dated 01/11/11

Worker's Compensation

Office notes Dr. dated 11/11/10 through 08/31/11

MRI of the right knee dated 05/04/11

X-rays, right knee, dated 11/11/10

Right shoulder x-rays dated 12/14/10

Cervical spine x-rays dated 11/11/10

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female whose date of injury is xx/xx/xx. Records indicate the claimant fell after getting her foot caught in a wire. She reports pain to the right knee and right shoulder.

She was noted to have had therapy and anti-inflammatory medications without relief of symptoms. She has difficulty with overhead activity. In her right knee, she gets pain when she walks a lot, squats, or kneels down. MRI of the right shoulder on 01/11/11 revealed a high-grade partial undersurface tear of the distal 1 cm of the supraspinatus and infraspinatus tendons at their insertion site. There is not tendon retraction, atrophy, or fatty infiltration within the muscle belly. There is partial tear of the longhead of the biceps tendon identified within the bicipital groove off the superior labrum. Severe AC joint hypertrophy with inferior osteophytic spurring and small broad-based subacromial spurring impinging the supraspinatus musculotendinous junction was noted with a large amount of fluid/bursitis in the adjacent subacromial/subdeltoid bursa communicating with a small amount of fluid in the subcoracoid bursa. Examination on 07/19/11 reported the claimant to be 5'6" tall and 165 pounds. Right shoulder exam reported no point tenderness. Range of motion testing reported elevation with pain actively to 100 degrees and passively to 130 degrees. External rotation was to 60 degrees and internal rotation to the sacral area. Impingement signs were not valid. On manipulation, there was no increased anterior, posterior, or inferior subluxation. Neurologic testing was 4/5 in the supraspinatus and 5/5 in internal and external rotators. Sensation was intact. MRI of the right shoulder was reviewed and noted to show a high-grade near-complete tear involving the supraspinatus and infraspinatus tendons, as well as a partial tear of the biceps tendon and large subacromial spur. The claimant was recommended to undergo arthroscopy and rotator cuff repair with subacromial decompression. Dr. did not think cortisone injection would be of benefit at this point. Continued observation of the right knee also was recommended.

Reconsideration/appeal request for outpatient right shoulder with rotator cuff repair and subacromial decompression was reviewed on 08/23/11 and non-certified as medically necessary. The reviewer noted there was an adverse determination of a previous review. In acknowledgement of the previous non-certification due to lack of documentation and failure of the claimant to respond to conservative measures, there is now documentation of previous physical therapy (undated, unspecified number of sessions). In addition, the claimant complains of right shoulder pain. Physical examination revealed active elevation to 100 degrees with pain and passively to 130 degrees, external rotation 60 degrees, and internal rotation to the sacral area. There was increased anterior, posterior, or inferior subluxation. Neurologic testing of 2/4 in the supraspinatus, intact sensation of the radial pulse of 2+. MRI report of 01/11/11 revealed high-grade partial undersurface tear of the distal 1 cm of the supraspinatus and infraspinatus tendons at their insertion sites with no tendon retraction, atrophy, or fatty infiltration. Partial tear of the long-head of the biceps tendon was noted. There was severe acromioclavicular joint hypertrophy with inferior osteophytic spurring and small broad-based subacromial spurring impinging the supraspinatus musculotendinous junction with a large amount of fluid/bursitis. However, despite documentation of prior physical therapy visits, there remains no documentation to failure of 3-6 months with conservative treatment including cortisone injections. There also is no documentation of tenderness over rotator cuff or anterior acromial area and positive impingement sign. Therefore medical necessity of the request was not substantiated.

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

Based on the clinical information provided, the proposed outpatient right shoulder surgery with rotator cuff repair and subacromial decompression is recommended as medically necessary. The claimant sustained an injury secondary to a fall and complained of right knee and right shoulder pain. Right knee pain improved somewhat, but right shoulder pain has been persistent since injury. The records indicate that the claimant has had therapy and anti-inflammatory medications, as well as activity modification without relief. She continues with difficulty with overhead activity. Physical examination revealed limited range of motion with active elevation to 100 degrees with pain. There was 4/5 weakness in supraspinatus testing. Noting that the claimant has objective findings of significant rotator cuff pathology, as well as impingement on MRI with physical examination findings that are consistent with imaging, and noting that the claimant has failed to respond to conservative care, surgical intervention with rotator cuff repair and subacromial decompression is indicated as medically necessary.

**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)