



Southwestern Forensic  
Associates, Inc.

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 09/09/11

**IRO CASE #:**

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

Shoulder surgery, rotator cuff repair, acromioplasty, and distal clavicle resection

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering shoulder problems

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. forms
2. forms
3. Certification page
4. Request for review by an independent review organization, 08/17/11
5. Denial letters, 06/24/11 and 07/15/11
6. Fax cover sheets, multiple, including 07/07/11
7. Clinical notes, 07/22/11 and 06/17/11
8. Surgical request and facility request, undated
9. MRI scan report, right shoulder, 06/11/11
10. Written request for expedited reconsideration, 07/06/11
11. Employee's claim for compensation for work-related injury or disease

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The injured employee is a female who suffered an injury to her right shoulder while working with a patient. Apparently the patient pulled on and struck her right shoulder, producing right shoulder injury. An MRI scan was performed on 06/11/11, revealing a full thickness tear of the distal extent of the supraspinatus portion of the rotator cuff.

Partial thickness tearing was documented and mild supraspinatus atrophy. Abnormalities in the labrum were noted as well as moderate acromioclavicular arthropathy. The patient suffers arthritis and was being treated with Methotrexate for arthritic complaints. Reportedly, she received a local injection in the shoulder provided by her rheumatologist. No other specific treatment was provided. The patient has been able to continue working full time. A surgical recommendation has been provided on the basis of the pathology demonstrated on the MRI scan. The request to preauthorize the right shoulder surgery including rotator cuff repair, subacromial decompression, and distal clavicle resection was considered and denied, reconsidered and denied.

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

The medical records submitted with this request to preauthorize rotator cuff repair, acromioplasty, and distal clavicle resection do not include specific range of motion information. There is no documentation of nonoperative treatment. The primary symptom appears to be pain. There is no documentation of physical therapy and/or efforts to modify activity to alleviate discomfort.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

*(Check any of the following that were used in the course of your review.)*

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)