

# Becket Systems

An Independent Review Organization  
815-A Brazos St #499  
Austin, TX 78701  
Phone: (512) 553-0360  
Fax: (207) 470-1075  
Email: manager@becketystems.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Apr/13/2012

**IRO CASE #:**

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

Right Shoulder Arthroscopic Rotator Cuff Repair

**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**

Official Disability Guidelines

Utilization review 02/22/12

Utilization review 03/01/12

Office visit M.D. 02/13/12

MRI right shoulder 01/10/12

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female whose date of injury is xx/xx/xx. She injured her right shoulder lifting car batteries. She has right shoulder pain radiating to right arm. MRI of right shoulder performed 01/10/12 revealed a 4 mm wide full thickness tear within anterior third of distal supraspinatus tendon with moderate intrasubstance increased signal within central and posterior third, compatible with approximately 20% intrasubstance tearing versus moderate tendinosis; mild infraspinatus tendinosis; sources for rotator cuff impingement in this patient include acromioclavicular joint arthrosis and mild lateral acromial downsloping; moderate subacromial / subdeltoid bursitis; small glenohumeral joint effusion. Per office visit dated 02/13/12 the claimant reported right shoulder pain is aggravated by lifting, movement, and range of motion. Pain is relieved by prescription medications. She has difficulty with lifting overhead or away from her body. Records indicate she has done therapy, anti-inflammatories, and injection in past with little relief. Physical examination reported the patient to be 5'2" tall and 210 lbs. Evaluation of right shoulder reported maximum tenderness to palpation of AC joint, with crepitus present. Lift off test was positive. Belly press was negative. The claimant was recommended to undergo right shoulder arthroscopy with rotator cuff repair.

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

The claimant sustained a lifting injury to right shoulder on xx/xx/xx. MRI of right shoulder revealed a 4 mm full thickness tear and findings compatible with approximately 20% thickness intrasubstance tearing versus moderate tendinosis. Sources for rotator cuff impingement were also noted. The patient reportedly has had some conservative treatment, and injection with little relief. However, there is no documentation as to the nature and extent of therapy completed to date including total number of visits completed, modalities used in response to treatment. There also is no detailed physical examination including range of motion measurements, strength testing, etc. Records indicate peer-to-peer discussion on 03/01/12 determined additional conservative treatment would be completed, along with documentation of strength or motion loss, and response to subacromial injection. None of this has been documented. As such the reviewer finds medical necessity is not established for Right Shoulder Arthroscopic Rotator Cuff Repair.

**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)