



14785 Preston Rd. Suite # 550 | Dallas, Texas 75254  
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision  
Amended and Sent on 7/07/2012

**DATE OF REVIEW:** 7/31/2012

**IRO CASE #:**

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

Left Rotator Cuff Repair Debridement/ Decompression/ Possible Bicep Tenodesis.

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

M.D. Board Certified in Orthopedic Surgery, Sports Medicine Orthopedics.

**REVIEW OUTCOME**

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

- Upheld
- (Agree
- Overturned
- (Disag
- ree)
- Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the clinical documentation, the patient was injured on xx/xx/xx when he sustained a fall onto his left shoulder. The patient was experiencing pain, although location and severity of pain not specifically noted, as well as limited motion. Stated physical examination details decreased range of motion, positive impingement tests, no weakness of the rotator cuff, and no instability. The patient has an MRI dated xxxxx with the following impressions:

- 1) Minimal articular surface partial thickness tear of the distal supraspinatus is superimposed on supraspinatus tendinosis



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- 2) Tendinosis of the infraspinatus and subscapularis
- 3) Mild tendinosis of the intraarticular portion of the long biceps tendon and mild tenosynovitis of the long biceps tendon
- 4) Moderate acromioclavicular osteoarthritis mildly encroaching the supraspinatus outlet as per radiologist report.

As of the date of the last correspondence of xxxxx, the patient has reportedly undergone physical therapy, treatment with anti-inflammatory medication, and corticosteroid injections to both the acromioclavicular joint and subacromial space with some temporary success. Per clinical report, the patient persists with symptoms despite these interventions although there is not clear documentation of subjective complaints.

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

Per ODG references, patient does not meet the criteria for surgery and the requested services: Left Rotator cuff repair Debridement/ Decompression/ possible Biceps Tenodesis are not medically necessary.

There has been no new documentation added to the clinical information since the last review. The medical record continues to fail to document a failure of exhaustive conservative measures. There is no documentation of type, dosage, or duration of pharmacologic treatment to demonstrate lack of response to optimized medical management. Only an initial physical therapy evaluation is documented with no follow up therapy notes documenting objective lack of progression with therapy and thus there is no objective demonstration that the patient is unlikely to improve with continued conservative care. Also, without follow up therapy notes there is no indication as to whether therapy treatments were complied with or were continuous. With no additional documentation added since the last review addressing these continued issues, the requested procedure remains non-confirmed.



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**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 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)