



**MEDICAL EVALUATORS
OF TEXAS** ASO, L.L.C.

1225 North Loop West • Suite 1055 • Houston, TX 77008
800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

DATE OF REVIEW: August 15, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder arthroscopy, acromioplasty, rotator cuff repair

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

This case was reviewed by a board certified Orthopaedic Surgeon currently licensed and practicing in the State of Texas.

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

Type of Document Received	Date(s) of Record
A progress note by MD	03/26/2012
A progress note by MD	04/09/2012
A progress note by MD	04/16/2012
A progress note by MD	05/14/2012
A progress note by MD	05/31/2012
A progress note by MD	06/06/2012
MRI of right shoulder	06/07/2012
A progress note by MD	06/11/2012
A H&P note by MD	06/20/2012
A progress note by MD	06/25/2012
A letter from xxxx	06/28/2012
A letter from xxxxx	07/17/2012
A request for IRO for denied services of "Right shoulder arthroscopy, acromioplasty, rotator cuff repair"	07/30/2012
A letter from from xxxxx	08/02/2012

EMPLOYEE CLINICAL HISTORY [SUMMARY]:



This is a female who sustained injury on xx/xx/xx. She was carrying a bag and laptop and was trying to open a door when she fell down sustaining injury to her right shoulder on trying to break the fall. She also noted pain radiating to her neck. She was initially seen by Dr. and was treated with physical therapy. She then had MRI done on xxxx that showed partial tear of supraspinatus tendon and was referred to ortho by Dr. On xxxxx, she was seen by Dr. and was recommended right shoulder arthroscopy, acromioplasty, and rotator cuff repair, which is denied.

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

These types of cases can be difficult. The neck and shoulder are closely connected. Therefore, the guidelines provide some guidance as to how to proceed. The guidelines apply in this case. Partial tears of the rotator cuff should be given the full 6 months of conservative care. The neck must be totally ruled out as the problem. Neither of these have been completed and both need to be honored.

ODG Indications for Surgery -- Rotator cuff repair:

Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:

1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS
2. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS
3. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS
3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

(Washington, 2002)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).



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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)