

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Review Decision

DATE OF REVIEW: August 6, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left rotator cuff repair 23929.

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

M.D., Board Certified in 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)

The requested procedure, left rotator cuff repair 23929, is not medically necessary for the treatment of this patient.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 7/16/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/18/12.
3. Notice of Assignment of Independent Review Organization dated 7/18/12.
4. Denial documentation.
5. Medical records from MD dated 2/23/12 through 5/09/12.
6. Texas Workers' Compensation Work Status Report dated 2/23/12, 3/09/12 and 4/20/12.
7. Operative report dated 3/19/12.
8. Left shoulder imaging report dated 2/23/12.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury to his left shoulder on xx/xx/xx when he fell off a piece of farm equipment and landed on his left shoulder. He had immediate pain. The pain slowly progressed, and the patient developed significant limitation in his range of motion with severe shoulder pain. An MRI of the left shoulder reportedly revealed a large tear at both the supraspinatus and infraspinatus tendons, with retraction to the mid-humeral head. The patient underwent left shoulder manipulation under anesthesia on 3/19/12. Postoperatively, the patient made some modest gains in his range of motion with physical therapy. On 4/20/12, he complained of continued pain in his left shoulder. On examination, the patient had 90 degrees of forward flexion, with weakness and tenderness to palpation of his left shoulder. The provider has recommended a rotator cuff repair.

The URA indicated that the patient does not meet Official Disability Guidelines (ODG) criteria for the requested procedure. Specifically, the URA's initial denial stated that ODG criteria for rotator cuff repair include conservative treatment for three to six months and positive imaging studies. Per the URA,

the clinical documentation submitted for review lacked evidence of original imaging studies to determine the necessity of the requested rotator cuff repair. Additionally, the URA indicated that there is a lack of evidence indicating that the patient had been treated with a course of physical therapy and pharmacological treatments for at least three to six months. On appeal, the URA indicated that it is unclear as to the specific duration, dates of service, and efficacy of physical therapy services to date.

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

The clinical information provided does not support the medical necessity of the requested left rotator cuff repair in this patient's case. This patient does not meet Official Disability Guidelines (ODG) criteria for the requested procedure. ODG criteria for rotator cuff repair include three to six months of conservative care. The criteria note that three months of conservative care is adequate if treatment has been continuous, and six months of conservative care is recommended if treatment has been intermittent. As noted by the ODG criteria, treatment must be directed toward gaining full range of motion, which requires both stretching and strengthening to balance the musculature. In this patient's case, the clinical documentation does not contain significant documentation regarding a reasonable course of conservative treatment which failed to improve the patient's functional status. The submitted documentation fails to demonstrate the specific duration, dates of service, and efficacy of physical therapy services to date. Thus, the patient does not meet ODG criteria for the requested left rotator cuff repair, and the requested procedure is not medically necessary for the treatment of this patient.

Therefore, I have determined the requested left rotator cuff repair 23929 is not medically necessary for treatment of the patient's medical condition.

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 KNOWLEDGBASE
- 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 NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)