

SENT VIA EMAIL OR FAX ON  
Jan/20/2012

## Independent Resolutions Inc.

An Independent Review Organization  
835 E. Lamar Blvd. #394  
Arlington, TX 76011  
Phone: (817) 349-6420  
Fax: (817) 549-0311  
Email: rm@independentresolutions.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**  
Jan/20/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Left Shoulder Excision Distal Clavicle, Acromioplasty, Rotator Cuff Repair

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**  
Board Certified Orthopedic Surgeon (Joint)

**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**

OD Guidelines  
Initial preauthorization UR review 12/20/11  
Appeal preauthorization UR review 12/27/11  
Preauthorization request 12/15/11  
Preauthorization appeal request 12/27/11  
MRI arthrogram left shoulder 11/17/11  
Office visits notes M.D.11/04/11-01/09/12

**PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a male who was injured on xx/xx/xx when ladder he was on slipped from under him and he caught himself with his left shoulder. He complains of left shoulder pain in certain positions and locking. Records indicate the injured employee was treated conservatively with therapy and medications. MRI of left shoulder obtained on 10/03/11 was noted to indicate fraying of supraspinatus with downsloping of the acromion giving rise to impingement. MR arthrogram performed on 11/17/11 reported articular surface tear of distal

1 cm of supraspinatus tendon without tendon retraction. There is degenerative subchondral cyst formation and degenerative bone marrow edema at greater tuberosity insertion on supraspinatus tendon. Fluid in subdeltoid bursa is consistent with bursitis. The claimant was seen in follow-up on 12/14/11. He is being followed with conservative treatment for tear of rotator cuff. MRI arthrogram on 11/17/11 showed tear of rotator cuff that is not complete. Conservative treatment includes use of sling and greatly restricted activities of work. The claimant reported having pain at night. She has been placed on Naproxen 500 mg bid. Physical examination showed the injured employee's range of motion continues to be good without sign of frozen shoulder. However, he complains of pain when trying to raise arm above shoulder level. Abduction is possible at 90 degrees before there is severe pain. He can reach fully overhead only and forward flexion. He can place his hands behind his back and behind his head. He can touch his operative shoulder. There is impingement with elevating arm above shoulder level either in forward flexion or abduction. Impingement is not much different with palm up position as opposed to palm down. There is palpable crepitus. There is positive cross arm sign. There is tenderness to palpation over the insertion of rotator cuff. It was noted the injured employee is not responding to conservative treatment of nonsteroidal anti-inflammatory drugs, activity modification, immobilization, and physical therapy. It was not felt cortisone injection was indicated because this might convert small tear in rotator cuff to larger tear. Injured employee was recommended to undergo left shoulder surgery.

An initial preauthorization UR review was performed in 12/20/11 and the request for Left shoulder excision distal clavicle, acromioplasty, rotator cuff repair was recommended for adverse determination. The reviewer spoke to Dr. who acknowledged the injured employee had partial tear of rotator cuff with type II acromion. Diagnostic anesthetic injections have not been performed. There is no radiographic evidence of degenerative joint disease of acromioclavicular joint. Necessity for distal clavicle resection is not established and adverse determination is recommended.

An appeal preauthorization UR review was performed on 12/27/11 and adverse determination recommended. It was noted the injured employee sustained a left shoulder injury after falling off a ladder. Left shoulder MRI arthrogram on 11/17/11 showed articular surface tear of distal supraspinatus tendon without tendon retraction, degenerative subchondral cyst formation and degenerative bone marrow edema at greater tuberosity insertion on supraspinatus tendon and fluid in subdeltoid bursa consistent with bursitis. Physician note dated 12/14/11 noted the injured employee with continued severe problems with left shoulder that included night pain. Examination findings are documented with left shoulder pain when trying to raise his arm above shoulder level, abduction at 90 before severe pain, impingement with elevating his arm above shoulder level, and palpable crepitus, positive cross arm sign, and tenderness over insertion of rotator cuff. Conservative treatment included medications, physical therapy, activity modification and light duty without benefit. According to the treating physician injection of cortisone was not indicated as it might convert small tear in rotator cuff to large tear. It was noted the records in this case document the injured employee has been in home exercise program, modified activities and anti-inflammatory medications. The records clearly document the claimant has not had subacromial injection. The treating physician suggested it might actually worsen the claimant's condition. There is no clear evidence to suggest subacromial injection which is typically recommended in evidence based literature would post greater risk to claimant than inherent risk associated with surgical acromioplasty and / or rotator cuff repair. Thus in this particular case the injured employee does not appear to have maximized all forms of conservative treatment and request for surgery cannot be considered reasonable or medically necessary at this time.

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

The request for left shoulder excision distal clavicle, acromioplasty, rotator cuff repair is indicated as medically necessary based on clinical data provided. The injured worker

sustained an injury secondary to a fall from a ladder and catching himself with his left shoulder on xx/xx/xx. MRI arthrogram performed 11/17/11 revealed an articular surface tear of the distal supraspinatus tendon without retraction, degenerative subchondral cyst formation and degenerative bone marrow edema at the greater tuberosity insertion on the supraspinatus tendon, and fluid in the subdeltoid bursa consistent with bursitis. Claimant was treated conservatively with NSAIDs, activity modification, immobilization and physical therapy without significant improvement. The requesting provider noted that injection of cortisone might convert a small rotator cuff tear into a larger tear. Office notes 12/23/11 indicated that the injured worker was informed of the physician reviewer's opinion regarding cortisone injection. The injured worker indicated that he was not interested in injections and wished to pursue surgical intervention. On examination it was noted the injured worker has positive impingement sign and positive cross arm sign. He has good range of motion except when attempting to raise his arm above shoulder level. The injured worker reports night pain. Based on the clinical data provided, it appears that the injured worker meets Official Disability Guidelines criteria for acromioplasty/rotator cuff repair except for cortisone injection. The injured worker does not wish to have a cortisone injection. Accordingly it appears that surgical intervention is indicated as medically necessary to address the injured worker's left shoulder pathology.

**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)