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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 03/14/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient arthroscopy and open rotator cuff repair of the left shoulder

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

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Outpatient arthroscopy and open rotator cuff repair of the left shoulder - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Preoperative evaluation from M.D. dated 08/03/09

Office visits with M.D. dated 09/22/09 and 03/01/10

Physical therapy requests dated 09/22/09 and 11/23/09

Physical therapy evaluations dated 09/23/09, 11/24/09, and 03/11/10

Physical therapy notes dated 09/23/09, 09/29/09, 10/01/09, 10/06/09, 10/08/09, 10/13/09, 10/17/09, 10/19/09, 10/24/09, 10/26/09, 12/01/09, 12/03/09, 12/08/09, 12/11/09, 12/15/09, 12/17/09, 12/22/09, 12/24/09, 12/29/09, 12/31/09, 01/07/10, 01/14/10, 01/21/10, 01/25/10, 01/29/10, 03/04/10, 03/05/10, 03/11/10, 03/15/10, 03/23/10, 03/25/10, 03/30/10, 04/01/10, 04/05/10, 04/07/10, 04/09/10, 04/11/10, 04/12/10, 04/14/10, 04/16/10, 04/21/10, 04/23/10, 04/28/10, 04/30/10, 05/03/10, 05/05/10, 05/07/10, 05/11/10, 05/12/10, 05/14/10, 05/17/10, and 05/19/10

Updated physical therapy plans of care dated 10/19/09, 12/08/09, 01/15/10, 04/14/10, and 05/19/10
Operative report dated 11/12/09
Left shoulder arthrogram MRIs dated 01/27/10 and 08/23/10
Operative report dated 02/18/10,
Physical therapy discharge summary dated 03/10/10
Evaluations with M.D. dated 09/23/11 and 12/20/11
Evaluations with M.D. dated 02/06/12
Preauthorization requests from Dr. dated 02/13/12 and 02/17/12
Preauthorization determinations from TASB dated 02/14/12 and 02/17/12
Notices from TML dated 02/16/12 and 02/22/12
Chart review for IRO dated 02/27/12 from Dr.
Prospective review from M.D. at TASB dated 03/01/12
TASB notes, undated
The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 08/03/09, Dr. recommended another stress test be performed and reviewed by the cardiologist and requested clarification of his anti-hypertensive regimen. On 09/22/09, Dr. evaluated the patient. He had right sided muscle guarding in the upper trapezius only. He was noted to be status post right rotator cuff repair improving following surgery. His Ultrasling was continued and therapy was prescribed three times a week for three weeks. Flexeril was prescribed. The patient underwent open repair of the subscapularis, supraspinatus, and infraspinatus tendons of the left shoulder on 11/12/09. A left shoulder MRI arthrogram was performed on 01/27/10 and revealed a large full thickness tear of the rotator cuff tendon involving the distal supraspinatus and infraspinatus tendons with tendinous retraction. There was fatty striation, most prominent within the infraspinatus muscle belly. Dr. performed open repair of the supraspinatus tendons of the left shoulder with Matrix HD graft on 02/18/10. On 03/01/10, Dr. reexamined the patient. Right shoulder flexion was 140 degrees and extension was 40 degrees. Abduction was 140 degrees and adduction was 40 degrees. Left shoulder ROM was not tested. He remained off of work and physical therapy was recommended. Another left shoulder MRI arthrogram was obtained on 08/23/10 and revealed postoperative changes in the shoulder, full thickness rotator cuff tear, complete disruption of the rotator cuff, as well as with the capsule of the shoulder, allowing 1 cm. of lateral subluxation of the humeral head from the glenoid, joint effusion, and osteoarthritic changes with spurring at the margin of the shoulder. On 09/23/11, Dr. noted a BRC had been scheduled and he recommended an EMG study and Flexeril and Hydrocodone were prescribed. On 12/20/11, the patient noted he had numbness and tingling down the arm into the hand, especially the 4th and 5th fingers. An orthopedic subspecialist evaluation was recommended, as well as an EMG study and cervical MRI. Flexeril and Hydrocodone were refilled. On 02/06/12, Dr. evaluated the patient. He noted a positive Drop sign and deltoid atrophy. Active ROM was 0 to 110 degrees. M.D., on behalf of TASB, provided an adverse determination for the requested left shoulder surgery on 2/14/12. On 02/17/12, M.D., also on

behalf of TASB, provided another adverse determination for the requested outpatient arthroscopy and open rotator cuff repair of the left shoulder.

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

This patient has failed three previous attempts at repair of the rotator cuff. This patient also on MRI scan had degenerative changes in the glenohumeral joint and a high-riding humerus. This is all indicative of rotator cuff arthropathy. This patient also has on MRI scan evidence of fatty infiltration of the supraspinatus and complete retraction of the tendon itself. A repeat surgery to redress the rotator cuff is similarly likely to fail. The ODG notes, in the Shoulder Section, that results of revision rotator cuff repair are inferior to those of primary repair. It also notes that while pain relief may be achieved in most patients, selection criteria include patients with an intact deltoid region, good quality rotator cuff tissue, and only one prior procedure. In my opinion, this patient does not meet the criteria as noted above for a repeat rotator cuff procedure. Therefore, the requested outpatient arthroscopy and open rotator cuff repair of the left shoulder is not reasonable or necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE
- 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)