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Notice of Independent Review Decision

DATE OF REVIEW: 3-7-2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of left shoulder arthroscopy vs. open acromioplasty, mumford and rotator cuff repair.

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

The reviewer is a Medical Doctor who is 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 reviewer agrees with the previous adverse determination regarding the left shoulder arthroscopy vs. open acromioplasty, mumford and rotator cuff repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following:

paperwork including utilization reviews/denials 1-23-2012 and 2-14-2012
reports 8-19-2008, 10-28-2011, 11-16-2011, 12-14-2011, 1-11-2012,
reports 12-28-2011, 12-5-2011
MRI report 11-7-2011
X-ray report 10-25-2011

Hand written office notes 8-19-2008 through 1-11-2012
Multiple DWC forms
letters 12-10-2011, 11-7-2011
Attending Physician Statement
FMLA paperwork
Prescriptions 11-16-2011, 10-28-2011
prescription

PATIENT CLINICAL HISTORY [SUMMARY]:

The female sustained a shoulder injury in the xx/xxxx. The clinical and radiographic findings included a painful shoulder impingement, bursitis and a partial tear of the rotator cuff, left shoulder. The November 11, 2011 dated MRI confirmed the undersurface cuff tear. The attending physician records were reviewed. The January 1, 2012 dated progress note discussed persistent left shoulder pain despite therapy and NSAIDS. There was impingement, tenderness and decreased motion noted in the records. The patient declined a cortisone injection and opted for surgery. Physical therapy records were reviewed and were from the Fall, 2011. Denial letters discussed the lack of established diagnosis of impingement and the lack of adequate non-operative treatment prior to a consideration for the proposed surgery.

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

Without the patient having undergone a comprehensive non-operative treatment protocol including corticosteroid injection(s), the provider's patient has not been tried and failed on all reasonable treatments. Additionally, a diagnostic injection test demonstrating relief of pain has not been performed on this patient. Applicable ODG criteria doesn't support surgical intervention in this situation in which there are reasonable, "conservative care" alternatives that have not been tried and failed.

Reference: ODG Shoulder Chapter

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.

ODG Indications for Surgery -- Acromioplasty:

Criteria for anterior acromioplasty with diagnosis of 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. 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 impingement.

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)