



**MEDICAL EVALUATORS
OF T E X A S 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 9, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open, chronic

**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
MRI of the right shoulder	07/06/2012
EMG/NCS of upper extremities	08/15/2012
MRI of the cervical spine	03/13/2013
MRI of the right shoulder	03/13/2013
Office visit	06/04/2013
A work comp pre-auth request form	06/06/2013
An initial IRO	06/13/2013
An adverse determination letter	06/13/2013
A letter	06/28/2013
An adverse determination reconsideration letter	07/05/2013
An second IRO	07/09/2013
An adverse determination reconsideration letter	07/09/2013



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A request for an IRO for the denied services of "Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open, chronic"	08/06/2013
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EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a female who fell on some cement stairs on xx/xx/xx and sustained injury to her right shoulder, neck, and ribs fracture. She had an MRI of right shoulder on 07/06/12 that showed mild tendinosis without evidence of rotator cuff tear, subacromial-subdeltoid bursitis, small glenohumeral joint effusion, and lateral acromion downsloping as a source of rotator cuff impingement. She then had EMG/NCS done on 08/15/2012 that showed moderated right and mild to moderate left carpal tunnel syndrome and chronic cervical radiculopathy involving the right C7 and C7 nerve roots. She had a repeat MRI of the right shoulder on 03/13/13 that was normal with no signs of injury to rotator cuff except for small joint effusion. MRI of the cervical spine dated 03/13/13 showed disc bulges at C3-4 and C4-5 with annular tears and mild cord compression and spondylosis at C5-6 with cord compression involving the left exiting nerve root. She was seen on 06/04/13 with chief complaints of right shoulder pain and limited motion. physical exam indicates the right shoulder flexion was 80°, abduction 100°, external rotation 60°, and internal rotation to L5. The motor testing of bilateral upper extremities was 5/5 throughout. Right biceps reflex was 1+, absent left biceps reflex, and 2+ brachioradialis and triceps reflexes. No sensory deficits in upper extremities. It was noted that she was treated with physical therapy and medications without much improvement. has recommended right shoulder acromioplasty distal clavicle resection and rotator cuff repair, which is denied by the insurance carrier.



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

The patient has failed a reasonable course of conservative modalities to alleviate her shoulder pain including physical therapy and medications. Of note, however, there was no documentation of physical therapy visits submitted with the request. Based on the surgeon's clinical note, the patient has obvious decreased range of motion documented compared to her contralateral side. There is MRI evidence of a downsloping acromion that would predispose her to subacromial impingement. There is not MRI evidence of a rotator cuff tear, although I would certainly agree with rotator cuff evaluation to rule out tear as part of the proposed procedure. I think that the patient meets ODG criteria 1, 2, and 4 for acromioplasty.

In evaluating criteria #3, the only objective criteria appears to be her limited range of motion. I found no mention of physical exam maneuvers for evaluating subacromial impingement or acromioclavicular degenerative disease (i.e. Neers, Hawkins, cross arm adduction, AC joint tenderness to palpation). Additionally, there is no documentation of a diagnostic injection to either the subacromial space or the AC joint. As the surgeon has requested acromioplasty, distal clavicle excision, and evaluation of the rotator cuff, I think that physical exam findings for this particular pathologic process and response to injections should be clearly documented prior to the case receiving approval. This was addressed by the previous 2 reviewers and appears to be the reason for the previous 2 adverse determinations. In conclusion, I do not believe that ODG criteria #3 has been adequately met. I agree with the 2 previous reviews and uphold the previous adverse determination.

ODG Indications for Surgeryä -- 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.



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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)