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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 6/10/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity outpatient arthroscopy, shoulder, subacromial decompression, and rotator cuff repair (RCR) to the left shoulder.

**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 disagrees with the previous adverse determination regarding the prospective medical necessity outpatient arthroscopy, shoulder, subacromial decompression, and rotator cuff repair (RCR) to the left shoulder.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Most recently on 5-9-13, the has been well-documented to have recurrent pain in the left shoulder. The pain has persisted since a slip and fall mechanism of injury. This has been noted to be despite treatment with restricted activities, medications and a cortisone injection. Exam findings have revealed tenderness and limited range of motion. There has been a positive drop arm sign and impingement tests. On 10-5-12, an MRI scan of the left shoulder revealed a significant and near complete (75 %) tear of rotator cuff, articular side. Degenerative changes of the AC joint were also noted, along with minimal osteoarthritis of the shoulder joint itself. Denial letters indicated that there was no provided/documentated physical therapy and that there was only a partial tear of the rotator cuff.

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

The claimant has had reasonable and comprehensive treatment over a period of 3-6 months. There have been documented persistent subjective and objective findings of impingement syndrome, including rotator cuff tear. This has been corroborated by the imaging studies and has been resistant to reasonable and recent non-operative treatments. The intent and essentially the letter of the applicable guideline criteria referenced below have been met. The procedures are medically necessary at this time.

**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. ([Washington, 2002](#))

**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)