

# CASEREVIEW

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## Notice of Independent Review Decision

[Date notice sent to all parties]: April 15, 2014

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Right Shoulder Scope with Open Revision of Torn Rotator Cuff, as an Outpatient

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

This physician is Board Certified in Orthopedic Surgery with over 40 years of experience.

### REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

#### PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He suffered a full-thickness tear of the rotator cuff with impingement and underwent surgery on October 1, 2013.

On October 1, 2013, Operative Report. Postoperative Diagnosis: 1. Right shoulder rotator cuff tear, full thickness. 2. Distal clavicle arthrosis. Procedures Performed: 1. Right shoulder rotator cuff repair. 2. Min-open with acromioplasty using Scorpion suture anchors and injection of the AmnioFix material to the rotator cuff tendon. 3. Distal clavicle resection.

On January 10, 2014, MRI of the Right Shoulder, Impression: 1. Acute partial thickness intrasubstance tear in the distal suprapinatus tendon. The tear extends in a laminar configuration over a length of 8 mm in the distal critical zone. 2. Grade 1 tenosynovits of the long head of the biceps. 3. Remote postoperative changes at the right acromioclavicular joint. 4. Small right glenohumeral joint effusion.

On January 15, 2014, the claimant was seen in follow-up for right shoulder pain. It was reported he was not currently working. On examination there was no misalignment or scapular winging. There was tenderness of the clavicle lateral one-third, the acromioclavicular joint, and the greater tuberosity. There was also tenderness of the supraspinatus and the infraspinatus. ROM was limited due to pain. Hawkins's test was positive and empty can sign was positive. O'Brien's was negative. There was no laxity and anterior apprehension test was negative. The claimant reported physical therapy was not helping.

On February 24, 2014, the claimant was evaluated who reported he started physical therapy following surgery but continued to have severe pain in the right shoulder. It was noted the claimant could not lift his arm. MRI performed on January 10, 2014 showed the claimant still had a tear of the rotator cuff supraspinatus tendon and that it had not healed but actually split the tendon with a laminar configuration. On examination of the right shoulder it was well healed with mild swelling. He could not lift his arm past 30 degrees forward flexion or 40 degrees abduction. He was very weak, over 50%, against resistance in external rotation, abduction and forward flexion. He had crepitation in the subacromial area. Assessment: Right shoulder torn rotator cuff with lack of healing or repair. The patient is having quite severe pain. Plan: Given a prescription for Hydrocodone 10/325 mg. Recommend right shoulder surgery; revision of the repair of the torn rotator cuff.

On February 24, 2014, Shoulder Diagnostic Ultrasound Examination interpreted. Impression: Right shoulder strain with torn rotator cuff. (Supraspinatus: Abnormal hyperechoic fibrillar pattern is present in the tendon with areas of tendinosis. Minimal tendon retraction was noted with rested dynamic abduction.)

On March 11, 2014, UR. Rationale for Denial: The request for right shoulder arthroscopy with open revision rotator cuff repair as an outpatient is not medically necessary. At this point, there is no documentation of a complete tear nor is there any indication how much therapy the claimant has completed thus far. Therefore, the request is recommended for non-certification.

On March 18, 2014, performed a UR. Rationale for Denial: The ODG does not specifically address revision rotator cuff repairs. As such, the criteria for rotator cuff repair will be utilized. In the setting of partial thickness tears, conservative management of at least 3 to 6 months of treatment including physical therapy is recommended. Based on the documentation provided, the injured worker certainly has both subjective and objective findings consistent rotator cuff tear. However, the clinician's interpretation on ultrasound is conflicting with the

radiologist interpretation of MRI. Given the lack of documentation of physical therapy or attempts at regaining motion and strength following the initial surgery and the conflicting imaging studies; the request is deemed not medically necessary and is not certified.

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

The previous adverse determinations are overturned. The Right Shoulder MRI dated January 10, 2014, revealed an acute partial thickness intrasubstance tear in the distal suprapinatus tendon. The tear extends in a laminar configuration over a length of 8 mm in the distal critical zone. The claimant has subjective and objective signs and symptoms of a rotator cuff tear as well. Postoperatively, the claimant did receive physical therapy which did not help. Therefore, the request for 1 Right Shoulder Scope with Open Revision of Torn Rotator Cuff, as an Outpatient if found to be medically necessary.

PER ODG:

**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.

(Washington, 2002)

For average hospital LOS if criteria are met, see [Hospital length of stay](#) (LOS).

**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)**