

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** May 24, 2010

**IRO CASE #:**

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

Right shoulder arthroscopy/subacromial decompression/labral repair

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

Certified, American Board of Orthopaedic Surgery

**REVIEW OUTCOME**

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Diagnostics (03/31/10)
- Office visits (10/08/09 - 04/08/10)
- Utilization reviews (04/22/10 – 05/05/10)
  
- Diagnostics (08/12/08 - 03/31/10)
- Office visits (10/01/09 - 02/22/10)
- Operative report (11/20/09)
  
- Medical evaluation (12/01/09)
- Office visits (07/21/08 – 01/08/10)
  
- Utilization reviews (04/22/10 – 05/05/10)

**ODG has been utilized for the denials.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who slipped on an oil spot on xx/xx/xx, and alleges injuries to his right shoulder, right knee and right foot.

**2008 – 2009:** The patient was initially seen at Medical Center (CMC) for pain in the right knee, anterior aspect of right shoulder, and right foot. Examination revealed positive Lachman's and drawer tests in the right knee and tenderness of the right acromioclavicular (AC) joint. X-rays were unremarkable. The patient was diagnosed with unspecified internal derangement of the knee, shoulder strain and foot strain and was treated with hydrocodone.

Magnetic resonance imaging (MRI) of the right knee revealed femoral-sided mild fraying of the lateral border of the medial meniscus near the root insertion, intact ACL graft, small Baker's cyst with evidence of recent leak, minimal tricompartmental chondromalacia and mild soft tissue edema.

D.C., saw the patient for right knee pain, right shoulder pain, neck pain, right foot pain, low back pain and headache. History was positive for asthma, right knee surgery, and sinus surgery. He was diagnosed with right knee joint pain, knee sprain/strain, shoulder tenosynovitis, shoulder sprain/strain, lumbar radiculopathy, lumbar segment dysfunction and foot tenosynovitis and ordered MRI of the knee, shoulder and lumbar spine and EMG/NCV of the lower extremities. He treated the patient with manual therapy, electrical stimulation, kinetic activities and hot/cold packs.

MRI of the right shoulder revealed insertional interstitial partial supraspinatus tendon tear, mild supraspinatus and infraspinatus tendinosis, AC joint arthritis with mild-to-moderate edema on both sides of the joint and minimal inflammation in the subacromial/subdeltoid bursa.

M.D., an orthopedic surgeon, saw the patient for right knee and right shoulder pain. Examination of the knee revealed moderate instability, mid medial and posterior medial joint line tenderness, positive McMurray's, anterior drawer and Lachman's. Examination of the shoulder revealed AC joint tenderness and positive impingement and supraspinatus signs. He diagnosed right shoulder pain, right medial meniscal tear, and sprain/strain of cruciate ligament of right knee. He performed KT 1000 and noted a large deficit with ACL laxity.

On November 20, 2009, M.D., an orthopedic surgeon, performed a revision and reconstruction of ACL graft of the right knee and removal of previous screws from ACL reconstruction. Postoperatively, the patient was placed on a brace and crutches and was encouraged to continue the exercise regimen.

On December 1, 2009, M.D., a designated doctor, opined that the extent of injury was right knee ACL tear, right rotator cuff tear and right foot sprain.

**2010:** In February, Dr. saw the patient for right shoulder catching and popping with slight decreased ROM and paresthesia in the distribution of the ulnar nerve. The patient also reported pain over the AC joint and area of the rotator cuff. Examination revealed pain and tenderness distal and lateral to the acromion, tenderness over the AC joint and positive adduction stress test. Active abduction was about 105, passive 125, active flexion was 120 and passive was 145. External rotation was almost normal while internal rotation was significantly decreased and was only about 40 to 50 degrees and 90 degrees of abduction of

the shoulder. Dr. assessed sprain/strain of the rotator cuff and shoulder impingement.

MRI of the right shoulder was obtained in March and revealed moderate thickening with increased signal involving the supraspinatus tendon indicating tendinopathy, no evidence of full-thickness tear, moderate hypertrophy of the AC joint with moderate inferior osteophyte formation mildly impinging upon the rotator cuff, mild fluid signal within the anterior deltoid muscle possibly related to recent injection or grade 1 muscle injury.

On April 8, 2010, Dr. recommended right shoulder arthroscopy and possible open repair of the rotator cuff as well as repair of the glenoid labrum.

Per utilization review dated April 22, 2010, right shoulder arthroscopy with subacromial decompression and labral tear was denied with the following rationale: *"This is a claimant with injury to the shoulder. It does not seem that lower levels of care have been exhausted; such as injection. MRI does not show a tear. Additional information from a peer-to-peer contact is needed to substantiate the medical necessity of the request."*

On April 30, 2010, the appeal for right shoulder arthroscopy with subacromial decompression and labral tear was denied with the following rationale: *"Patient sustained an injury dated xx/xx/xx, and complained of shoulder pain. MRI of the right shoulder dated March 30, 2010, revealed moderate thickening with increased signal involving the supraspinatus tendon indicating tendinopathy. There is no evidence of full-thickness tear. Moderate hypertrophy at the AC joint with moderate inferior osteophyte formation mildly impinges upon the rotator cuff. Mildly strand fluid signal within the anterior deltoid muscles is non-specific and may be related to recent injection or grade I muscle injury. In the clinical notes dated April 8, 2010, physical examination of the right shoulder showed ROM on abduction of 105 degrees actively, passive of 125, flexion 120 degrees actively and 145 degrees passively with tenderness over the distal and lateral to the acromion and over the AC joint with positive adduction stress test. Based on the submitted clinical information, the patient underwent physical therapy treatment, medications and injections. There was no noted type II or type IV SLAP lesion that necessitates surgical intervention in the MRI reports. The necessity of the request was not established."*

On May 5, 2010, the request for right shoulder arthroscopy was denied with the following rationale: *"As per medical reports, the patient complained of right shoulder pain. Pertinent physical findings noted tenderness over the distal and lateral to the acromion and over the AC joint. Active abduction was about 105 degrees, passive of 125 degrees, flexion 120 degrees actively and 145 degrees passively. There is positive adduction stress test. MRI of the right shoulder dated March 31, 2010, revealed moderate thickening with increased signal involving the supraspinatus tendon indicating tendinopathy. There is no evidence of full-thickness tear. Moderate hypertrophy at the AC joint with moderate inferior osteophyte formation mildly impinges upon the rotator cuff. Based on the guidelines, surgical consideration can be considered if there is failure of conservative management like physical therapy, medications and activity modification. The clinical records indicated that the patient had been treated conservatively with oral medications and physical therapy. As such the*

*appropriateness, medical necessity, and anticipated benefits of this requested procedure are not sufficiently substantiated.”*

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

The requested services have included right shoulder arthroscopy with subacromial decompression and labral repair. There is insufficient evidence of MOI, symptoms, MRI findings, or clinical findings that would be consistent with a labral tear. The requests for surgery appear to have been appropriately reviewed and determined per ODG criteria.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**