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Notice of Independent Review Decision

DATE OF REVIEW: December 9, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Extensive shoulder debridement, long biceps tendon tenodesis, decompression of subacromial space, remove/transplant tendon

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

TDI

- Utilization reviews (08/22/11 – 09/16/11)

Political Subdivisions

- Reviews (12/29/10 – 10/14/11)
- Utilization reviews (06/15/11 – 09/16/11)
- Office visits (11/11/10 – 09/15/11)
- Procedures (01/3/11)
- Diagnostics (04/19/11)

Orthopedics Physical Therapy

- Therapy visits (5/3/11 – 7/7/11)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male working as a . On xx/xx/xx, he was loading a water pump onto a flat bed truck with a coworker. The coworker let go off his end, and the water pump fell

with the claimant still holding onto it. He alleges an acute injury to his right elbow. He did not notice the pain until the next day when he had pain to the lateral aspect of his elbow while hammering.

The patient was initially evaluated by M.D., and treated for two weeks with Celebrex, a wrist splint and work restrictions with no relief. He then presented to M.D., who noted localized tenderness to the lateral epicondyle that was reproduced by full elbow extension and wrist flexion/extension. Dr. diagnosed right lateral epicondylitis and injected the lateral epicondyle and common tendon area with Depo-Medrol and Marcaine. The patient was started on physical therapy (PT) with very little relief. He denied any specific shoulder symptoms or other injuries.

On January 3, 2011, the patient underwent repair of common extensor tendon of the right elbow. Postoperatively, he was encouraged on gentle range of motion (ROM) exercises. In February, the patient was returned to work with restrictions on hammering, repetitive gripping, or lifting more than 20 lbs.

On March 10, 2011, the patient presented with lot of pain in the right elbow and also his shoulder with some irritability of the shoulder motion. He lacked approximately 40 degrees of full abduction and elevation. There was subdeltoid tenderness. X-rays of the right shoulder were within normal limits. Dr. injected the subacromial space with Depo-Medrol and Marcaine. This did not give him any relief.

Magnetic resonance imaging (MRI) of the right shoulder was obtained on April 19, 2011, showing mild tendinopathy in the distal fibers of the supraspinatus tendon without associated tear and mild fibrous hypertrophic changes of the acromioclavicular (AC) joint with no significant narrowing of the subacromial space.

Per July 7, 2011, note from physical therapist at Orthopedics, noted the patient had attended 14 sessions of physical therapy and still was unable to work as his job was very physical. Audible "popping" of the right shoulder was noted. He was to complete three more sessions of therapy as approved by the insurance company.

On August 11, 2011, M.D., a shoulder specialist, examined the right shoulder and noted moderate tenderness in the biceps groove, moderate subacromial crepitus, mildly positive Neer, Hawkin's, cross arm and O'Brien's tests, decreased muscle strength and some myofascial trigger points noted. Dr. diagnosed right-sided subacromial bursitis and superior glenoid labrum lesion. He recommended starting nonsteroidal antiinflammatory drugs (NSAIDs), activity restrictions, and surgery to include subacromial decompression, debridement and biceps tenodesis.

On August 22, 2011, the request for right shoulder extensive debridement, long biceps tendon tenodesis, decompression of subacromial space, remove/transplant tendon was denied by M.D., with the following rationale: *"The claimant has no objectified pathology of significant impingement by MRI. The claimant did not receive any relief with subacromial injection. The claimant only had a mildly positive Neer and Hawkin's tests. Guidelines indicate there should be conservative care of three to six months to regain full range of motion including stretching and strengthening, pain with active arc of motion 90-130 degrees plus night pain and objectified abduction weakness or demonstrable atrophy of the tendons of the rotator cuff, positive impingement temporarily relieved by anesthetic injection. The claimant only has a mildly positive*

impingement sign with radiation of pain to the lateral arm and scapula with no improvement with subacromial injection.”

On September 15, 2011, Dr., noted the patient had attended physical therapy and tried over the counter NSAIDs without relief. Tenderness over the biceps groove was noted along with stiff range of motion with an internal rotation to the level of L5. He had a positive impingement sign as well as positive O’Brien’s sign. He noted the MRI showed tendinopathy of the supraspinatus and SLAP tear and recommended surgery.

On September 16, 2011, the appeal for the right shoulder surgery was denied by , M.D., with the following rationale: *“This patient had a strain to the right upper extremity when he and a coworker were lifting an object. The initial symptoms were to the right elbow and he had a surgery for the right lateral epicondylitis. The MRI of the right shoulder did not show any acromion downsloping anteriorly or laterally nor any biceps tear or subluxation. The rotator cuff was not torn. The patient had an injection subacromially that did not provide benefit. The patient has equivocal findings on exam of the right shoulder. The need for the biceps tenodesis versus tenotomy and the debridement are not validated by the imaging study. Further delineation of the pain generator is needed.”*

On September 28, 2011, M.D., performed a peer review and gave the following opinions: The extent of injury included a right lateral epicondylitis status post surgery and right shoulder strain (if the late onset right shoulder symptoms were accepted). No additional treatment related to right shoulder symptoms per Official Disability Guidelines (ODG) as related to the work event and the proposed surgery would not be reasonable or causally or related to the work event. The effects of the October 25, 2010, would have been expected to resolve by this time.

On October 14, 2011, M.D. (specialty credentials not identified), performed a designated doctor evaluation (DDE) and opined that regarding the extent of injury, the patient did have a medial epicondylitis and tendon involvement of the right elbow. The patient also did have some internal injury to the insertion of the biceps tendon, the long biceps and the short head. He did have some signs suggesting impingement syndrome of the right shoulder. He had mild tendinopathy of the distal fibers of the supraspinatus tendon without an associated tear. He had some mild fibrous hypertrophic changes of the AC joint but no significant narrowing of the subacromial space. The injury obviously caused the injury to his elbow. The injury to the shoulder certainly involved a sprain or strain and maybe tearing of the fibrous strands of the biceps insertion. The patient did not have an AC joint separation and did not seem to have shoulder bursitis.

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

Based on the documentation provided herewith, including the preauthorization reviewers’ rationale, their adverse determinations appear to be reasonable and justified, per ODG criteria. There is insufficient evidence that the claimant sustained an acute injury to the right shoulder, and insufficient evidence that his symptoms are related to the vague clinical findings and the relatively benign MRI findings.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES