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Notice of Independent Review Decision

DATE OF REVIEW: January 24, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder arthroscopic subacromial decompression, distal clavicle excision and rotator cuff repair.

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

Fellow American Academy of Orthopaedic Surgeons

REVIEW OUTCOME

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

Upheld (Agree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office visits (06/08/10 – 11/04/10)
- Diagnostic (08/17/10)
- Therapy (08/13/10 – 11/10/10)

TDI

- Utilization reviews (11/11/10 – 11/24/10)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was proceeding along at 55 miles/hour in a double tractor trailer on xx/xx/xx. The tires broke traction on a wet road causing the truck to jack-knife and do a 180. The truck rolled down a twelve foot embankment landing on the driver's side.

On xx/xx/xx, D.C., evaluated the patient for sharp pain in the low back bilaterally radiating down the left hip, left leg, left foot and left shoulder pain. Dr. noted that

following the injury, the patient was taken to the emergency room (ER) where a urine sample was collected. Subsequently, the patient was seen by Dr. who obtained x-rays. He attended nine to ten sessions of physical therapy (PT) which did not benefit him but made his pain worse. History was positive for low back surgery in 2007 after a motorcycle crash. Examination revealed decreased lumbar range of motion (ROM) due to pain; decreased flexibility in the low back and lower extremities; decreased left shoulder ROM; decreased strength in the lower extremity muscles; hypoesthesia and pain in the dermatome areas L3, L4 and L5; positive Valsalva maneuver for the low back; positive supraspinatus press test and positive straight leg raising (SLR) on the left with mild to moderate pain at the left thigh at 75 degrees and moderate pain with palpation of the left mid thoracic spine, thoracolumbar and iliolumbar group and slight pain at the left trapezius and rhomboid. Magnetic resonance imaging of the lumbar spine dated July 20, 2010, revealed postoperative changes at L4-L5 with probable partial discectomy, narrowing of the left neural foramina and lateral recess that appeared to be related to disc protrusion rather than scar tissue, degree of neural encroachment slightly improved on the left since the previous exam and degenerative spondylosis elsewhere in the lumbar spine. Dr. diagnosed muscle spasms, rotator cuff sprain/strain, shoulder stiffness, lumbar sprain/strain, disc degeneration and intervertebral disc disorder with myelopathy. He prescribed capsaicin cream and recommended electrodiagnostic study of the lumbar area due to positive minors sign to the left leg and weak muscles on the left lower extremity and recommended therapy for the low back. From August through November, the patient attended 15 sessions of PT consisting of therapeutic exercise and shoulder taping.

In August, MRI of the left shoulder revealed high-grade partial thickness tearing greater than 50% of the articular sided fibers of the distal supraspinatus tendon; partial thickness articular sided tear of the distal subscapularis tendon; mild infraspinatus tendinosis; intraarticular portion of the long head of the biceps tendon was attenuated and thinned compatible with partial thickness tear and/or chronic tendinosis and abnormal signal and morphology of the anterior and posterior labrum compatible with degenerative tearing. In functional capacity evaluations (FCE) in August and September, the patient qualified at a light physical demand level (PDL) versus very heavy PDL required by his job. In the interim, Dr. noted no change in the examination findings. He recommended continuing PT and medications.

On November 4, 2010, M.D., evaluated the patient for left shoulder pain which failed to respond to the appropriate conservative treatment and PT. Examination of the left shoulder revealed full but guarded ROM, positive Neer and Hawkins impingement signs, tenderness over the AC joint, slight weakness in external rotation due to pain. Dr. reviewed the MRI and diagnosed left shoulder pain not responsive to the conservative care and near full thickness tear of the supraspinatus. He recommended left shoulder arthroscopic subacromial decompression, distal clavicle excision and rotator cuff tear repair.

Per utilization review dated November 11, 2010, the request for left shoulder arthroscopic subacromial decompression, distal clavicle excision and rotator cuff repair was denied with following rationale *"The patient is a male who sustained injury on xx/xx/xx. PT note dated June 23, 2010, reported the patient had completed four sessions of treatment. Clinical note dated xx/xx/xx, reported the*

patient was initially injured when he was involved in a motor vehicle accident. In that report, the patient complained of low back pain with radiation to the lower extremities. The patient also complained of aching pain in the left shoulder. MRI of the left shoulder dated xx/xx/xx, reported findings of high-grade partial thickness tearing of the articular-sided fibers of the distal supraspinatus tendon, partial-thickness articular-sided tearing of the distal subscapularis tendon, mild infraspinatus tendinosis, partial-thickness tear of the elongated biceps tendon and degenerative tearing of the anterior posterior labrum. Clinical note dated November 4, 2010, reported the patient complained of significant left shoulder pain and has been treated with PT. Physical exam of the left shoulder reported full, but guarded ROM, positive Neer, positive Hawkins impingement signs, tenderness of the acromioclavicular joint and slight weakness in external rotation. The request for left shoulder arthroscopic subacromial decompression with clavicle excision and rotator cuff repair is not medically necessary at this time. The MRI study submitted for review indicated the patient had evidence of partial-thickness tearing of the distal supraspinatus tendon, subscapularis tendon, and long head of the biceps tendon. Documentation indicates the patient has been previously treated with PT; however, no PT summary notes for the left shoulder were submitted for review to assess duration and efficacy of treatment. Official Disability Guidelines recommend that patients should be responsive to 3 – 6 months of conservative care before partial-thickness rotator cuff tendons or before patients should undergo surgical intervention for partial-thickness rotator cuff tears. As such, the clinical documentation provided does not support the certification of the request at this time.”

Per reconsideration review dated November 24, 2010, the appeal for left shoulder arthroscopic subacromial decompression, distal clavicle excision and rotator cuff repair was denied with following rationale: *“The patient is a male who sustained an injury on xx/xx/xx, when he was involved in a motor vehicle accident. The patient initially complained of pain within the left shoulder and initial physical exam performed xx/xx/xx, revealed mild restrictions in the right shoulder range of motion. The patient was noted to begin PT on June 23, 2010. The patient was also placed on Naproxen and Vicodin on June 25, 2010. The MRI of the left shoulder dated August 17, 2010, revealed a high-grade near full thickness articular sided tear of the inferior fibers of the distal supraspinatus tendon. Thickening of the subscapularis tendon is present. Thinness and attenuation of the biceps tendon is noted consistent with chronic partial thickness tearing and tenderness. Mild to moderate acromioclavicular joint arthropathy is noted and the patient has concave chromium. The follow-up on November 4, 2010, states the patient has continued left shoulder pain that has not improved with conservative treatment and physical therapy. The physical exam revealed full but guarded range of motion of the left shoulder with positive Neer and Hawkin’s impingement signs. Tenderness over the acromioclavicular joint is noted and there is weakness on the external rotation. The patient was recommended for rotator cuff repair and subacromial decompression. The clinical documentation provided for review does not support the request for surgery. The patient does have evidence consistent with a partial thickness/near full thickness tear of the supraspinatus tendon with evidence consistent with impingement of the right shoulder; however, the clinical documentation provided for review has minimal documentation regarding physical therapy for the patient’s left shoulder. The patient has undergone extensive physical therapy for the patient’s low back pain complaints; however there is only one PT note regarding*

the patient's shoulder from xx/xx. No other conservative care has been documented for the patient to date. Current evidence based guidelines recommend the patient be refractory to a reasonable course of conservative therapy before considering rotator cuff repair or subacromial decompression. Given the limited documentation provided for review regarding the patient's prior conservative therapy, medical necessity is not supported at this time."

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

This patient has a positive history, physical findings and imaging studies consistent with a partial tear of the rotator cuff and development of an impingement syndrome. The reason for this denial is there is no documentation the patient has had lower level of care for three to six months including physical therapy for strengthening and stretching, anti-inflammatory medication and/or subacromial injections. This has been noted by other reviewers.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**