

**AccuReview**  
An Independent Review Organization  
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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**

Rt shoulder poss RCR subacromial decomp, slap repair, biceps tenotomy

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

This physician is a Board Certified Orthopedic Surgeon with 43 years of experience.

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

On September 4, 2009, an MRI of the right shoulder was performed. Impression: Degenerative signal at the supraspinatus tendon without a definite surface reaching tear. Degenerative changes in the subcortical region at the greater

tuberosity of the humeral head. Otherwise negative MRI of the shoulder. There are mild osteoarthritic changes in the acromioclavicular joint without evidence of any impingement as interpreted by M.D.

On July 19, 2010, the claimant was evaluated by M.D. He has persistent pain and discomfort. He gets a feeling of crepitation, as well as clicking and popping. There is palpable crepitation in the anterior inferior glenohumeral joint. Positive internal rotation adduction test consistent with a labral injury. Impression: Labral injury to right shoulder.

On July 20, 2010, the claimant was evaluated by DO. He has a feeling of instability and sharp stabbing pain that hurts when he lifts and pushes things. Positive cross arm, empty can, speeds test. Impression: 1. Right shoulder probabic labral tear. 2. Possible partial thickness tear rotator cuff, right shoulder. 3. Biceps tendinosis.

On August 20, 2010, an MRI Arthrogram of the right shoulder was performed. Impression: Supraspinatus and infraspinatus tendinopathy with degenerative signal in the posterior superior labrum and small cystic change in the posterior aspect of the humeral head may be secondary to posterior impingement. A discrete labral tear is not identified as interpreted by M.D.

On September 9, 2010, the claimant was re-evaluated by DO. Right shoulder pain described as sharp and throbbing which is aggravated by lifting. He is to continue physical therapy.

On September 24, 2010, the claimant was re-evaluated by, DO. His symptoms have remained unchanged since the previous visit. His right shoulder was injected with 3 mL of methylprednisolone acetate, 40 mg and 7.0 mL Bupivacaine.

On November 4, 2010, the claimant was re-evaluated by DO. The pain is aching and dull with secondary decreased mobility, popping, tenderness and weakness. He has had failed conservative treatment. Dr. recommended diagnostic shoulder arthroscopy.

On November 17, 2010, D.O., a physical medicine and rehabilitation physician, performed a utilization review on the claimant. Rational for Denial: There is no evidence of a positive rotator cuff tear or slap lesion to warrant surgical intervention. The documentation indicates the patient has been unresponsive to physical therapy; however no physical therapy notes were submitted for review to assess duration and efficacy to treatment. Therefore, it is not certified.

On December 20, 2010, M.D., an orthopedic surgeon, performed a utilization review on the claimant. Rational for Denial: Objective documentation of the patient's response to optimal conservative measures are needed in the medical

report with assessments in terms of VAS scale for pain control, reduction in medication use and performance of activities of daily living. He has elevation to 160 degrees and external rotation to 65 degrees. There is mild pain with impingement testing. Cross arm abduction test is negative. There is no scapular winging. Therefore, it is not certified.

### **PATIENT CLINICAL HISTORY:**

On xx/xx/xx, the claimant sustained an injury to the right shoulder when he was lifting when his arm was jerked.

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

Per the medical records submitted, there is no evidence of a positive rotator cuff tear or slap lesion to warrant surgical intervention. Furthermore, based on the medical records submitted conservative care has not yet been exhausted. Based on the ODG Guidelines the previous decisions are upheld.

### **Per the ODG:**

Recommended as indicated below. **Criteria** for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear. ([Washington, 2002](#)) ([de Jager, 2004](#)) ([Kaplan, 2004](#))

### **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.

Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See [SLAP lesion diagnosis](#). The advent of shoulder arthroscopy, as well as our improved understanding of shoulder anatomy and biomechanics, has led to the identification of previously undiagnosed lesions involving the superior labrum and biceps tendon anchor. Although the history and physical examinations as well as improved imaging modalities (arthro-MRI, arthro-CT) are extremely important in understanding the pathology, the definitive diagnosis of superior labrum anterior to posterior (SLAP) lesions is accomplished through diagnostic arthroscopy. Treatment of these lesions is directed according to the type of SLAP lesion. Generally, type I and type III lesions did not need any treatment or are debrided, whereas type II and many type IV lesions are repaired. ([Nam, 2003](#)) ([Pujol, 2006](#)) ([Wheeless, 2007](#))

**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)**