

SENT VIA EMAIL OR FAX ON
Jun/23/2011

Applied Assessments LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/23/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder Arthroscopy with Possible Rotator Cuff Repair

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

MD board certified orthopedic surgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

1. Orthopedic consult and follow up reports Dr. 09/21/10 through 05/10/11
2. X-ray reports Dr. lumbar, left shoulder and cervical 09/21/10 and 04/18/11
3. Initial consultation Dr. XX/XX/XX
4. Manual muscle testing/range of motion 04/18/11, 01/28/11, 11/30/10, 10/29/10
5. MRI right shoulder 03/03/11
6. MRI left shoulder 11/15/10
7. MRI cervical spine 11/15/10
8. MRI lumbar spine 08/03/10
9. Operative report lumbar epidural steroid injection 06/03/11
10. Pre-authorization determination letters regarding certification medical necessity for lumbar epidural steroid injection and amendments
11. Adverse determination letter 06/06/11 regarding non-authorization reconsideration right shoulder arthroscopy with possible rotator cuff repair
12. Adverse determination letter 05/24/11 regarding non-authorization medical necessity for right shoulder arthroscopy with possible rotator cuff repair
13. Operative report left shoulder arthroscopic examination with subacromial decompression, debridement of partial rotator cuff tear and partial labral tear
14. Pre-authorization determination letter pre-authorizing medical necessity for left shoulder arthroscopy
15. Operative report cervical epidural steroid injection 04/07/11
16. Pre-authorization determination letter and amendments regarding pre-authorization medical necessity for cervical epidural steroid injection C5-6
17. Operative report lumbar epidural steroid injection 01/28/11
18. Pre-authorization determination letter medical necessity lumbar epidural steroid injection L4-5

19. Operative report lumbar epidural steroid injection 10/25/10
20. Pre-authorization determination letter medical necessity lumbar epidural steroid injection L4-5

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a XX-year-old male whose date of injury is XX/XX/XX. The injured employee was injured secondary to a motor vehicle accident in which another vehicle ran a stop sign and struck the injured employee's vehicle. The injured employee is noted to have sustained injuries to the neck, low back, left knee and left shoulder. The injured employee has been treated with physical therapy, medications as well as epidural steroid injections to the cervical and lumbar spine. After a course of conservative care for the left shoulder including subacromial injection that provided significant but temporary relief, the injured employee underwent left shoulder surgery on 05/04/11 with subacromial decompression and debridement of partial rotator cuff tear and partial labral tear. MRI of the right shoulder was performed on 03/03/11 and revealed prominent hypertrophic change along the AC joint with mild impingement upon the proximal supraspinatus tendon. The glenohumeral joint showed some thinning, but the margins of the glenoid and humeral head were well maintained. There was some thinning of the glenoid labrum but no tear identified. Rotator cuff showed thinning and grade 1 to 2 signal change typical for some degeneration, and thinning along the mid portion was typical for partial tear. There was no fluid in the subacromial or subdeltoid bursa as typically seen with complete rotator cuff tear. The injured employee was seen in follow up on 05/10/11 and was very happy with the results of left shoulder surgery. He still complains of pain and popping in the right shoulder. He still had neck pain with some tingling in the bilateral thumbs. Physical examination reported positive Lhermitte's sign as well as positive Spurling's sign reproducing pain out into his arms. There was C6 paresthesias bilaterally. Right shoulder exam revealed weakness in abduction and positive impingement sign with no evidence of instability.

An adverse determination letter of utilization review dated 05/24/11 noted that request for right shoulder arthroscopy with possible rotator cuff repair was not authorized as medically necessary. It was noted that peer review guidelines indicate three months of conservative care should be completed prior to surgical consideration to gain full range of motion with stretching and strengthening. Also the claimant should have subjective pain with active arc motion 90-130 degrees and pain at night. Objective findings should include weakness or absent abduction or atrophy, and there should be objectified pathology by imaging and temporary relief from anesthetic injection. It was noted that the injured employee had had no conservative treatment for the right shoulder but has received medication and cortisone injection with no objectified partial thickness rotator cuff tear or demonstrable weakness to the right shoulder, with ongoing pain with reaching and overhead soreness pain rated 3/10 with limited stay at abduction at 130 degrees, and positive impingement without documented physical therapy specified for the left shoulder, surgical care is not yet medically indicated. Noting that as it has not been specified whether the injured employee had physical therapy for the right shoulder without documented results of subacromial shoulder injection right shoulder surgical decompression is not medically indicated.

Adverse determination letter dated 06/06/11 indicated that reconsideration request for right shoulder arthroscopy with possible rotator cuff repair was non-authorized as medically necessary. The rationale for denial noted the claimant had alleged multiple areas of symptoms and has had prior left shoulder surgery. There is minimal discussion of the right shoulder. There was no clinical injection assessment of the AC joint provided. There was no indication that the injured employee would need an extensive synovectomy/debridement CPT 29823 nor that there would need to be a separate coding for the arthroscopy of the joint. The necessity for the multiple interventions at multiple areas appears unusual and further validation of the current request for shoulder surgery as submitted was needed. RME would appear to be warranted to provide further objectivity to the necessity of the proposed procedures.

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

Based on the clinical information provided, medical necessity is not established for right shoulder arthroscopy with possible rotator cuff repair. The injured employee was injured secondary to motor vehicle accident on XX/XX/XX. Initial consultation on XX/XX/XX noted the injured employee sustained injuries to his cervical, thoracic and lumbosacral spine region as well as left knee. No mention was made of the shoulders. The injured employee subsequently complained of bilateral shoulder pain. He underwent left shoulder arthroscopic surgery on 05/04/11 after failing a course of conservative care. The injured employee continued to complain of right shoulder pain. Examination of the right shoulder performed 04/18/11 reported tenderness over the anterolateral aspect with limited range of motion with abduction to approximately 130 degrees. There was limited internal and external rotation with pain. There was no instability noted. There was positive impingement sign. The injured employee underwent right subacromial injection on this date; however, follow up on 05/10/11 did not document response to this injection. There was no evidence that the injured employee had had other conservative treatment including physical therapy directed specifically to the right shoulder. Per Official Disability Guidelines, there should be three to six months of conservative care including stretching and strengthening exercises directed to regaining full range of motion prior to consideration of surgical intervention. Three months is adequate if treatment is continuous and six months if treatment is intermittent. Guidelines also indicate that there should be subjective clinical findings including pain with active arc motion 90-130 degrees and pain at night. This is not documented. Objective findings should include weak or absent abduction or possible atrophy, and tenderness over rotator cuff or anterior acromial area, and positive impingement sign and temporary relief of pain with anesthetic injection. As previously noted there was no documentation of the response to subacromial injection. As such, the proposed right shoulder arthroscopy with possible rotator cuff repair is not supported as medically necessary.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES