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## Notice of Independent Review Decision

**DATE OF REVIEW:** 9/12/11

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of 29823 Extensive shoulder debridement, 29826 Decompression of subacromial space and 23412 repair of ruptured musculotendinous cuff, Ch.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

### **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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of 29823 Extensive shoulder debridement, 29826 Decompression of subacromial space and 23412 repair of ruptured musculotendinous cuff, Ch.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: Dr.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: 7/19/10 to 7/29/11 office notes and consultations by Dr., 5/11/11 to 8/22/11 telephone conference forms, 9/20/10 to 4/18/11 lumbar, cervical, and shoulder x-ray reports, 10/29/10 to 4/18/11 reports, 11/15/10 left shoulder and cervical MRI reports, 8/30/10 lumbar MRI report,

6/3/11 operative report, 6/3/11 procedure note, 6/3/11 procedure order, 5/20/11 preauth determination letter amended, 4/25/11 preauth determination, 6/6/11 denial letter, 5/24/11 denial letter, preauth request form, operative photos 5/4/11, 5/4/11 operative report, 4/21/11 surgery reservation sheet, 4/26/11 script, 4/25/11 letter to Mr., 4/7/11 operative report, 4/2/11 procedure note, 12/9/10 procedure order, 12/14/10 preauth letter, 2/11/11 preauth letter, 1/28/11 operative report, 10/25/10 operative report, 9/30/10 procedure order and 10/5/10 preauth determination letter.

8/9/11 denial letter, 8/22/11 denial letter, 6/23/11 IRO report, 5/19/11 surgery reservation sheet, 9/21/10 to 7/29/11 office notes by Dr., 4/18/11 report and 3/3/11 right shoulder MRI report.

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The male was injured in a vehicle accident on xx/xx/xxxx, with resultant neck, left arm and leg, back and bilateral shoulder pain. The patient has a history of having undergone a left shoulder arthroscopy in 5/11. The claimant has ongoing right shoulder pain and popping. Exam findings included positive impingement and painful weak shoulder abduction, as of AP records dated 5/10/11 and thereafter. Neck pain with radiation, a positive Spurling (reproducing shoulder pain) and paresthesias in the bilateral distribution was noted. A subacromial injection only provided temporary relief. A 3/11 dated right shoulder MRI revealed AC changes with cuff impingement, along with thinning of the glenohumeral joint, labrum and rotator cuff (with probable partial tear). Denial letters note the lack of specific shoulder-associated post-injection therapy, the lack of recent specific delineation of functionality and motion deficit of the shoulder, and, the possible significant consideration of other pain generators. The claimant had been noted to have 90% relief in neck and significant improvement of the shoulder symptoms from a cervical ESI and has been considered for cervical surgery.

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

The lack of comprehensive post-injection shoulder physical therapy, recent delineation of shoulder motion and functionality deficit, and, the possible pain cervical spine pain generators do not adequately support an indication for the proposed procedures. Without reasonable delineation of the diagnosis and pain generator being from the shoulder vs. cervical spine, and, without documentation of a recent comprehensive trial of therapy and possible additional injection, the proposed procedures are not reasonable and medically necessary at this time.

ODG Indications for Surgery -- Acromioplasty: Criteria for anterior acromioplasty with diagnosis of 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. 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 Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement. (Washington, 2002)

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. (Washington, 2002)

**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)