

**CALIGRA MANAGEMENT, LLC**  
**1201 ELKFORD LANE**  
**JUSTIN, TX 76247**  
**817-726-3015 (phone)**  
**888-501-0299 (fax)**

---

Notice of Independent Review Decision  
**IRO REVIEWER REPORT TEMPLATE –WC**

---

**August 9, 2012**

**IRO CASE #:**

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

Arthroscopic subacromial decompression, AC resection and rotator cuff debridement of left shoulder.

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

Board Certified Orthopedic Surgeon

**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.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

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

**xxxxxx**

- Office visits (02/03/11 – 06/22/12)
- Therapy (02/11/11 – 04/15/11)
- Diagnostics (10/08/11 – 05/31/12)
- Utilization reviews (06/15/12 – 07/05/12)

**Dr.**

- Office visits (02/03/11 – 06/22/12)
- Therapy (02/11/11 – 04/15/11)
- Diagnostics (10/08/11 – 05/31/12)

**TDI**

- Utilization reviews (06/15/12 – 07/05/12)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who on xx/xx/xx, was carrying a 150-pound valve at work. He hyperextended the left elbow while trying to manipulate and shift the valve.

**2010:** No records are available.

**2011:** On February 3, 2011, the patient was seen at xxxxx. He was status post distal biceps tendon repair and left shoulder strain/tear. The evaluator noted that the patient was 10 weeks status post injury and three weeks status post tendon repair. There was mild edema throughout the left upper extremity especially at the forearm and elbow. The cervical range of motion (ROM) had decreased in extension and sidebending to the right. The scapular protraction/retraction was decreased and shoulder active ROM was significantly limited. The elbow ROM was also significantly limited. The patient complained of numbness from the incision site distal along the C6 area down to the dorsum of the thumb and hypersensitivity of the remainder of the arm. The patient was wearing an adjustable flexion/extension splint. The evaluator recommended 18 sessions of physical therapy (PT).

From February through April 2011, the patient attended 10 sessions of PT consisting of soft tissue mobilization, ROM and strengthening and scar tissue mobilization.

In October, magnetic resonance imaging (MRI) of the left shoulder revealed mild partial-thickness bursal surface tear of the supraspinatus tendon, mild subscapularis and supraspinatus tendinopathy and acromioclavicular (AC) and glenohumeral osteoarthritis.

In November, M.D., evaluated the patient for significant spasms around the neck, significant pain in the shoulder with motion at the shoulder and decreased ROM which was quite disabling. The patient reported another fall recently in which he twisted his right knee again and had been treated with corticosteroid injection. History was positive for right knee surgery and right wrist surgery. Examination of the left shoulder revealed decreased ROM and impingement on examination. The patient was able to resistively abduct and forward flex the arm without marked weakness but it was quite painful. Dr. reviewed MRI of the cervical spine that revealed a disc space protrusion at around C5-C6, some foraminal stenosis on the right and some mild stenosis at C3-C4 and C6-C7 with bilateral foraminal stenosis. Dr. diagnosed left shoulder partial rotator cuff tear with impingement and cervical spine arthritis with radiculopathy. He recommended corticosteroid injection and therapy that had helped in the past and felt that the patient was a candidate for a shoulder arthroscopy. On follow-up, the patient reported that the injection helped for about a week and therapy was not helpful. Dr. recommended evaluation for surgical treatment.

**2012:** On January 17, 2012, M.D., evaluated the patient for left shoulder injury. Dr. noted that the patient was picking up a valve and slipped and fell to the ground. He had also sustained an injury to his right knee requiring surgery. The

patient complained of difficulty using the arm over his head, pain while using the arm, pain at rest and at night, pain with overhead activities and with below shoulder level activities. The patient also reported shoulder weakness and stiffness. History was positive for heart disease, diabetes, hypertension and hypercholesterolemia. Surgical history was positive for heart surgery, knee surgery, right wrist surgery, eye surgery and right biceps tendon repair. Examination of the left shoulder revealed decreased ROM, pain with abduction, positive impingement sign and swimmer's sign, localized pain to the lateral aspect of the shoulder and tenderness over the AC joint. X-rays of the shoulder revealed significant AC joint arthritis and downsloping type II to III acromion. He also reviewed MRI of the left shoulder and cervical spine and recommended surgery.

On January 31, 2012, Dr. noted significant impingement syndrome with a partial-thickness rotator cuff tear. The request for left shoulder surgery had been denied. Dr. recommended evaluation by a spine surgeon and administered a subacromial injection.

In February, the patient complained of neck pain and stiffness radiating down the left shoulder and arm causing numbness and tingling in the left arm. , M.D., noted limited cervical ROM bilaterally, positive Spurling's on the left, difficulty relaxing, visible atrophy of the right hand intrinsics and leaning to left while seated because of pain across the shoulder. The motor exam was inhibited due to pain in the left upper extremity. There was ganglion cyst over the left radial wrist and limited shoulder evaluation secondary to pain. The patient was unable to flex or abduct the shoulder beyond 30 degrees due to pain. Dr. reviewed MRI of the left shoulder and cervical spine and diagnosed status post work-related injury with left shoulder partial rotator cuff tear and impingement syndrome, status post left biceps tendon repair, left cervical radiculopathy symptoms versus possible concomitant peripheral nerve entrapment and right ulnar neuropathy. He recommended electromyography (EMG) of the left upper extremity to evaluate the possibility of spinal nerve injury versus entrapment neuropathy given the multifactorial injuries.

In May, electromyography/nerve conduction velocity (EMG/NCV) of the left upper extremity revealed mild-to-moderate left carpal tunnel syndrome (CTS) affecting the sensory and motor components of the nerve.

On June 12, 2012, Dr. noted ongoing neck pain and left shoulder pain. Examination of the cervical spine revealed marked pain with full extension of the neck, some pain with rotation and extension to the left causing significant left shoulder pain and pain with rotation to the right. Examination of the left shoulder revealed positive impingement and swimmer's sign. Dr. opined that if Dr. recommend anything further regarding neck then that will be done prior to submitting another request for subacromial decompression.

Per utilization review dated June 15, 2012, the request for arthroscopic debridement, subacromial decompression, rotator cuff repair of the left shoulder

(CPT 29805, 29822, 29826 and 23410) was denied with the following rationale: *“The documentation submitted for review elaborates the patient complaining of ongoing left shoulder pain. The Official Disability Guidelines recommend a rotator cuff repair provided the patient meets specific criteria to include completion of 3 months of conservative care as well as significant clinical findings. The clinical notes detail the patient stating he had initiated PT; however, he did not continue secondary to ongoing pain. There is a lack of information regarding the patient’s significant clinical findings to include pain with active arc of motion from 90 to 130 degrees, as well as night pain complaints and weakness associated with abduction. Given the lack of information regarding the patient’s completion of conservative care and taking into account the lack of information regarding the patient’s significant clinical findings, this request does not meet guidelines recommendations. As such, the documentation submitted for this review does not support this request at this time.”*

On June 22, 2012, the patient complained of ongoing left shoulder pain. Dr. discussed with Dr. and he did not feel that the patient had a radiculopathy. The patient had mechanical neck pain but Dr. felt that surgery for neck was not needed. The patient reported difficulty with activities of daily living, inability to raise the arm overhead without pain and difficulty sleeping. Examination of the cervical spine revealed marked pain with full forward flexion causing posterior neck pain and some pain with rotation to the right causing pain in the posterior neck. Examination of the left shoulder revealed decreased ROM, marked pain with abduction and positive impingement and swimmer’s sign. Dr. opined that the patient had significant impingement syndrome, some early degenerative changes in his glenohumeral joint and partial-thickness rotator cuff tear. He discussed conservative treatment with reinjection and PT versus consideration of a decompression and AC joint resection. The patient requested surgery as he had failed conservative treatment.

On July 5, 2012, the appeal for arthroscopic debridement, subacromial decompression and rotator cuff repair of the left shoulder was denied with the following rationale: *“The request for an appeal of a previous non-certified request for the left shoulder arthroscopy rotator cuff repair is not clinically warranted. The request was previously not certified on June 14, 2012, due to lack of documentation of three months of conservative treatment and lack of clinical functional deficit on physical examination warranting the need for surgical intervention per the guidelines recommendations. The additional Information provided for review includes physical examination findings from June 22, 2012. The request again remains not certified as full documentation of three months of conservative treatment care has not been provided. The claimant does have diagnostic evidence of cervical degenerative disease although the MRI was not provided for review and has documented evidence of left shoulder osteoarthritis and glenohumeral degenerative changes. Improvement was noted with a prior corticosteroid injection; however, only limited for one week. There is no significant functional documented muscular atrophy, night symptoms or associated weakness or atrophy in abduction that would indicate or meet the clinical*

*guidelines recommendations to proceed with surgical intervention at this time. The guidelines state that at least three months of conservative treatment failure should be documented including formal physical therapy and oral medications and pain with active arc motion of 60-130 degrees with subjective night symptoms which should be noted. Weakness or absent abduction should be documented with possible muscular atrophy, these have not been provided in the records; therefore, proceeding with the surgical intervention at this time does not appear to be clinically warranted.”*

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

It certainly appears that an injury to the left shoulder has been documented in this case. The left shoulder MRI of 10/08/11 confirmed mild partial ligamentous injury to the supraspinatus with some underlying age related changes. The acromioclavicular and glenohumeral arthritis was also documented. There was an inferior acromioclavicular osteophyte which can contribute to the impingement process. Injection therapies have failed. Physical therapy also appears to have failed. The treating physician has continued to document positive impingement signs with a curved acromion and significant acromioclavicular degenerative change. The electrodiagnostics do not appear to reveal cervical radiculopathy. However it does not appear that adequate physical therapy was provided under the evidence based guidelines.

The Official Disability Guidelines clearly outline that at least three months of continuous care would be recommended to include physical therapy. In this case it does not appear that the physical therapy recommendation has been satisfied. Other portions of the guidelines have been satisfied including the persistence of tenderness, impingement findings with failure of an injection as well as operative pathology on the imaging studies. It appears that a fairly limited course of therapy was provided in this case. If the treating physician could document that this resulted in a sustained home exercise program which also was unsuccessful in alleviating the claimant's condition, then the therapy provided coupled with failure of home exercises, coupled with the failure of time, medications and injections along side the persistent clinical findings and imaging findings, then I believe the guidelines could be considered satisfied. Without that simple clarifications the guidelines remain technically unsatisfied for the proposed surgical intervention.

---

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Official Disability Guidelines Treatment in Worker's Comp, 17<sup>th</sup> edition, 2012 Updates, chapter shoulder

**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.

Criteria for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint:

**1. Conservative Care:** At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS

**2. Subjective Clinical Findings:** Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS

**3. Objective Clinical Findings:** Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS

**4. Imaging Clinical Findings:** Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation.