

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: July 18, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder Arthroscopy with Subacromial Decompression, Rotator Cuff Repair, Glenohumeral Debridement, and Mumford 29822, 29826, 29827

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

The physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

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:

11-17-11: Right Shoulder X-Ray, Two View at Medical Centers dictated by The DO
11-17-11: Office visit at Medical Centers dictated by MD
11-28-11: Progress Note at Medical Centers dictated by MD
12-05-11: Follow up note at Medical Centers dictated by MD
12-12-11: Progress Note at Medical Centers dictated by MD
12-21-11: MR Arthrogram of the Right Shoulder at Diagnostic MRI dictated by MD
12-28-11: Injury Recheck Encounter at Medical Centers
12-28-11: New patient consultation at US Med Group dictated by MD
12-28-11: Texas Workers' Compensation Work Status Report completed by MD
01-18-12: Follow up note at Group dictated by MD
01-18-12: Injury Recheck Encounter at Medical Centers
01-18-12: Hand Therapy Prescription at Medical Centers
02-15-12: Injury Recheck Encounter at Medical Centers
02-15-12: Follow up note at Group dictated by MD
02-15-12: Texas Workers' Compensation Work Status Report completed by MD
02-22-12: Injury Recheck Encounter at Medical Centers
02-22-12: Follow up note at Group dictated by MD

04-05-12: Progress note at Medical Centers dictated by MD
04-25-12: Follow up visit note at Medical Centers dictated by MD
04-25-12: Injury Recheck Encounter at Medical Centers
04-25-12: Prescriptions prescribed by MD
05-07-12: Office visit note at Orthopaedic Specialists dictated by MD
05-14-12: Phone note at Orthopaedic Specialists
05-15-12: UR performed by MD
06-07-12: UR performed by MD
06-07-12: Phone note at Orthopaedic Specialists

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whom was injured while at work on xx/xx/xx when he was loading a pressure washer with a co-worker when he felt an immediate onset of right shoulder pain which was exacerbated by further lifting but was not alleviated by anything. He continued to have right shoulder pain for two months, when he saw his PCP but was given medications which did not improve his ability to move. The injury was reported to the supervisor at the time of injury.

11-17-11: Rights shoulder x-ray, two view dictated by The DO. Impression: Normal right shoulder.

11-17-11: Office visit dictated by MD. Claimant presented with right shoulder pain. Translator was used for this visit. Physical Examination: Right Shoulder: Decreased ROM of shoulder noted to flexion (limited at about 90 degrees), abduction (limited at about 90 degrees) and internal rotation to the level of L5. Pain was noted during the ROM testing. Positive impingement noted strength testing of supra spinatus demonstrated weakness to resistance. Positive Apley scratch test noted negative anterior apprehension noted pain with resisted flexion in full supination. Some catching was noted in passive ROM testing. Palpation of the shoulder demonstrated moderate tenderness at the infraspinatus, pectoralis major/anterior chest wall and teres major. Assessment: 1. Rotator cuff strain 840.4, 2. Shoulder impingement 726.2. Plan: MRI of right shoulder with intra-articular contrast. Modified activity: no use of right arm. Ice packs 15 minutes at a time, no longer than 15 minutes, protecting skin from direct contact with the ice and waiting at least 45 minutes between applications. Two large gel packs were provided to the [patient. Naproxen 500 mg po BID with food. Thera-gesic apply BID-QID prn pain. One tube provided. Follow up 11/28 for MRI report.

11-28-11: Progress note dictated by MD. Claimant has been working within duty restrictions; taking prescribed medications and has noted some improvement of symptoms. Claimant has had physical therapy and feels a slight improvement in his functional status. Claimant reported less pain than previous visit. Pain is exacerbated by attempting to reach overhead and alleviated by medications and resting; pain reaches 9/10 in tensity when reaching. No numbness, but marked weakness in the arm at the shoulder. Left Shoulder: Decreased ROM of shoulder noted to flexion (limited at about 30 degrees), abduction (limited at about 30 degrees). Pain was noted during the ROM testing both active and passive. Positive impingement noted strength testing of supraspinatus demonstrated weakness to resistance. Positive Apley scratch test noted and pain with resisted flexion in full supination. Palpation of the shoulder demonstrated moderate tenderness at the infraspinatus, pectoralis major/anterior chest wall and teres

major. Assessment: Derangement joint, shoulder 718.81. Plan: Still awaiting approval for MRI. Continue modified activity. No use of the right arm. Continue Naproxen 500 mg po BID with food. Continue ice packs 15 minutes at a time, no longer than 15 minutes, protecting skin from direct contact with the ice and waiting at least 45 minutes between applications. Continue physical therapy three times a week. Follow up on Monday.

12-05-11: Injury recheck encounter from Medical Centers dictated by Locum Provider. Claimant seen for follow up visit secondary to impingement of the right shoulder rotator cuff. Claimant has limited range of motion to the right shoulder to 90 degrees with pain in the same area. Diagnosis: Rotator cuff sprain. Treatment Plan: Claimant sent for additional physical therapy.

12-12-11: Progress note dictated by MD. Claimant has been working within the duty restrictions, taking prescribed medications with no noted improvement and had physical therapy in which he stated a slight improvement in his functional status. Claimant reports less pain rated at 6/10 without radiation. Pain is exacerbated by attempting to reach overhead and alleviated by medication and resting. He reported he is still unable to use his right shoulder, with profound weakness but no numbness or subjective instability. Physical Examination: Right Shoulder: Decreased ROM of shoulder noted to flexion (limited at about 120 degrees), abduction (limited at about 90 degrees). Positive impingement noted strength testing of supraspinatus demonstrated weakness to resistance. Positive Apley scratch test noted. Palpation of the shoulder demonstrated moderate tenderness at the deltoid, coracoids process and supraspinatus. Assessment: Derangement joint, shoulder 718.81. Plan: Still awaiting approval for MRI ordered on 11/17/11. It is almost certain that he has a structural derangement, likely ligament tear or labral lesion. Exam at this time is consistent with rotator cuff tear. Refer to Dr. orthopedic surgeon. Continue with plan for MRI. Continue ibuprofen as prescribed by the Locum Tenens provider, although it is not clear why he changed to a different NSAID. Continue modified activity: no lifting over 5 pounds with the right hand or arm; no pushing or pulling over 5 pounds with the right hand or arm; no reaching above shoulders; may drive tractor. Continue HEP provided by PT.

12-21-11: MR Arthrogram of the Right Shoulder dictated by MD. Impression: 1. Mild to moderate insertional tendinopathy of the supraspinatus and infraspinatus tendons without tear. Right rotator cuff otherwise normal. 2. Moderate osteoarthritic changes within the inferior aspect of the glenohumeral joint, worse posteriorly where there is grade III chondromalacia and underlying periarticular cystic changes within the underlying posterior bony glenoid. Small osteophytic spurring at the inferomedial aspect of the humeral head. 3. SLAP type I tear. There is a glenoid labral articular disruption, which extends the entire length of the posterior labrum, worst at its posterior inferior aspect where there is at least a moderate amount of osteoarthritic changes noted. 4. Not mentioned above, mild synovitis with a few subcentimeter intra-articular bodies/gravel within the inferior recess of the glenohumeral joint secondary to the osteoarthritic cartilage loss. 5. Moderate AC joint hypertrophy with inferior osteophytic spurring together with some minimal subacromial spurring impinging the supraspinatus musculotendinous junction with a small amount of underlying subacromial/subdeltoid bursitis.

12-28-11: New patient consultation note dictated by MD. Chief Complaint: Right shoulder. Physical Examination: Musculoskeletal: Right Shoulder: Has normal appearance. Tenderness diffusely but mostly along the acromioclavicular joint and anterolateral acromion. He has 85 degrees of forward flexion, 60 degrees abduction, and internal rotation to the hip pocket. All provocative signs including Neer's, Hawkin's, Jobe's, and drop-arm are positive. Imaging: X-rays are normal with minor findings of acromioclavicular joint narrowing. MRI consistent with arthrosis, SLAP and posterior labral tear, and supraspinatus tendinopathy. Assessment: Right shoulder labral tear with some degenerative features, also acute-on-chronic injury making this worse, some subacromial impingement, and acromioclavicular impingement. Plan: Surgery may ultimately be needed as he has not gotten better with 6 months time; however, injection will be attempted first. He will request the injection and have him back when that is completed. He will suspend his therapy for now and work on his exercises at home.

01-18-12: Follow up visit note dictated by MD. Claimant stated no changes in right shoulder with intermittent pain up to 8/10. Claimant stated he has not been doing therapy or taking medications; and feels like, overall, it is getting somewhat better. On exam, claimant does have impingement signs including Jobe's, Hawkin's, Neer's, and internal and external rotation impingement, as well as pain with Jobe testing. Neurovascular status intact. Claimant received injection in the right subacromial bursa. Plan to continue claimant on light duty and see him back in 3 weeks. If claimant is better, we can give him a full release; otherwise, surgery would be indicated.

01-18-12: Hand therapy prescription at Medical Centers. Increase range of motion, increase strength, and provide home exercise program to be done 2 times/week for 4 weeks.

02-15-12: Follow up note dictated by MD. Claimant stated he better. Whenever he reaches above his head or across his chest or behind his back, he has a painful catch. Claimant noted that he is fine as long as he is working at waist level, but he really cannot do much involving overhead or behind the back movement. Claimant stated that he has been working and he had to raise his arm over his head, and that causes the pain to get quite a bit worse. Claimant has completed a lot of therapy and injection into the subacromial bursa with temporary and partial relief. Claimant requested another injection. Dr. noted that another injection would not only give the claimant any chance of long-lasting improvement especially since the first one was short-lived. Dr. described and recommended surgery for subacromial decompression with Mumford, glenohumeral debridement, and biceps tenotomy. Alternative treatment would be to have a permanent work restriction which would likely require functional capacity evaluation or retirement.

02-22-12: Follow up note dictated by MD. Claimant stated still having pain in the right shoulder, not really any better; and requested time to recover. Dr. recommended to release patient due to no active treatment unless pain changes, claimant's symptoms gets worse, or anything becomes different and he request a follow up. Impairment rating ordered.

04-05-12: Progress note dictated by MD. Claimant presented with pain located on anterior aspect of the right shoulder. Physical Examination: Right Shoulder: Decreased active and passive ROM: Tenderness of shoulder diffusely. Assessment: Shoulder injury, claimant wants to be referred to Dr. who claimant states told him he needs surgical intervention. Refer to Dr..

04-25-12: Follow up note dictated by MD. Claimant presented with continued right shoulder pain 9/10 and considering surgery. Claimant stated he had a reinjury, not sure exactly when, but thinks it was 2 months ago where his shoulder was forced into extension, and he has not been able to raise it since then. Dr. noted right shoulder has 10 degrees of flexion and minimal internal and external rotation. Marked tenderness around the anterolateral shoulder. Nonoperative treatment has been maximized. There is a high index suspicion for rotator cuff tear. The previous MRI did not show a large full tear, but he certainly exhibits those characteristics on exam today possibly because of the new injury. Recommend right shoulder arthroscopy with subacromial decompression of rotator cuff and other indicated repairs if they are found at the time of surgery. Prescriptions for Naproxen 500 mg po BID with food and Tylenol #3 1 to 2 po Q4 hour per pain.

05-17-12: Office visit note dictated by MD. Claimant presented with complaints of right shoulder pain as continuous sharp and severe pains a 10/10 at worst; with worsening pains when reaching overhead, reaching behind the back, lying on the shoulder, light lifting. Associated symptoms: stiffness, clicking, upper extremity pain. Right Shoulder Exam: Tenderness: coracoids, anterolateral acromion, posterolateral acromion, bicipital groove. Active ROM: Flexion: 38; Internal Rotation (side) S1; External Rotation (at side): 26. Provocative: Neer 3+, Hawkins 3+, Jobe 3+, Cross chest 1+, Drop arm positive. X-ray of right shoulder: acromion type II: there are few cysts at the greater tuberosity. MRI right shoulder (12/21/11): Rotator Cuff: supraspinatus tendinopathy; Labrum: SLAP I tear; Joint abnormality: glenohumeral, acromioclavicular. Impression: NON-Orthopedic Diagnoses: HYPERTENSION HX OF, RIGHT ROTATOR CUFF TEAR: subacromial impingement glenohumeral synovitis and chondromalacia. Dr. noted he is fairly sure there is a rotator cuff tear though MRI done 6 months ago showed no tear. Claimant has a drop arm sign and has gotten worse with nonoperative treatment. Plan: Right shoulder arthroscopy, subacromial decompression, rotator cuff repair, glenohumeral debridement, Mumford. Nonoperative Treatments attempted, which have had temporary effect, or no effect, in improving the patient's condition: activity modification, therapy, splinting, injection. Worker's Comp Summary: Work Status: restricted with the right, MMI: not at MMI.

05-15-12: UR performed by MD. Reason for denial: Guidelines indicate in order to undertake rotator cuff repair, imaging must show positive evidence of a deficit in the rotator cuff. The MRI on 12/12/11 documented the rotator cuff as normal with no tears identified. Guidelines indicate for subacromial decompression, lower levels of care of three to six months must be undertaken and there must be subjective findings of pain at night and pain of arc motion of 90-130 degrees with objective clinical findings such as weak or absent adduction and positive impingement sign and temporary relief with anesthetic injection. Imaging must show evidence of impingement. Records reflect the claimant had an injection with temporary relief and has undergone physical therapy and use of oral medication medications without significant benefit. Imaging demonstrates

evidence of impingement on the MRI of December 2011. Guidelines for repair for SLAP lesion repair surgery type II and type IV lesion only. The claimant's MRI noted he had a type I SLAP lesion. The request is not certified.

06-07-12: UR performed by MD. Reason for denial: The previous non certification by Dr. on 5/15/12 reported the guidelines indicate in order to undertake rotator cuff repair, imaging must show positive evidence of a deficit in the rotator cuff. The MRI on 12/12/11 documented the rotator cuff as normal with no tears identified. Guidelines indicate for subacromial decompression, lower levels of care of three to six months must be undertaken and there must be subjective findings of pain at night and pain of arc motion of 90-130 degrees with objective clinical findings such as weak or absent adduction and positive impingement sign and temporary relief with anesthetic injection. Imaging must show evidence of impingement. Records reflect the claimant had an injection with temporary relief and undergone physical therapy and use of oral medications without significant benefit. Imaging demonstrates evidence of impingement on the MRI of 2011. Guidelines for repair for SLAP lesion repair surgery type II and type IV lesion only. The claimant's MRI noted he had a type I SLAP lesion. I agree with the previous reviewer's non certification, there are no additional medical records for review. There is no documentation of rotator cuff tear by MRI and no evidence of a type II or type IV SLAP lesion by diagnostic imaging. Based on the medical records available for review, the previous reviewer's non certification and the peer review evidence based Official Disability Guidelines the request for reconsideration right shoulder arthroscopy and subacromial decompression and rotator cuff repair glenohumeral debridement, and mumford procedure would not be supported as medical indicated.

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

I agree/uphold the denial as previous reviewing doctors of this case have done. I do not think there is any indication on the MRI of acute injury or rotator cuff injury or a SLAP tear of II or III variety. After reviewing the medical records and documentation provided, it appears that the claimant's symptoms and findings are due to an impingement syndrome which is secondary to degenerative changes; this would not be injury related. Therefore, the request for Right Shoulder Arthroscopy with Subacromial Decompression, Rotator Cuff Repair, Glenohumeral Debridement, and Mumford 29822, 29826, 29827 is denied.

Per ODG:

Surgery for rotator cuff repair	<p>ODG Indications for Surgery™ -- Rotator cuff repair: Criteria for rotator cuff repair with diagnosis of <u>full thickness</u> 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.</p>
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	<p>Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of <u>partial thickness</u> rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)</p> <p>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</p> <p>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</p> <p>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</p> <p>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)</p> <p>For average hospital LOS if criteria are met, see Hospital length of stay (LOS).</p>
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<p>Partial claviclectomy (Mumford procedure)</p>	<p>ODG Indications for Surgery™ -- Partial claviclectomy:</p> <p>Criteria for <u>partial claviclectomy</u> (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint:</p> <p>1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS</p> <p>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</p> <p>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</p> <p>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.</p>
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<p>Surgery for SLAP lesions</p>	<p>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)</p>
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<p>Surgery for impingement syndrome</p>	<p>ODG Indications for Surgery™ -- Acromioplasty:</p> <p>Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.)</p> <p>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</p> <p>2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS</p> <p>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</p>
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	4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement. (Washington, 2002)
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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 KNOWLEDGBASE
- 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)