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Notice of Independent Review Decision

DATE OF REVIEW: May 29, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder arthroscopy, subacromial decompression and debridement
29826, 29822

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

Fellow American Academy of Orthopaedic Surgeons

REVIEW OUTCOME

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

Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who on was xxxxx developed right shoulder pain.

On, M.D., evaluated the patient for right shoulder pain which was more intense when lifting up. The patient reported numbness and tingling in the right upper extremity and decreased range of motion (ROM). Examination of the right shoulder showed tenderness on the anterior aspect and decreased ROM. X-rays of the right shoulder were unremarkable. Dr. assessed unspecified derangement of joint of right shoulder region, prescribed Flexeril and Ultracet and recommended physical therapy (PT) and warm compression to the right shoulder.

From xxxx, through xxxxx, the patient attended four sessions of PT consisting of cold packs, neuromuscular reeducation, therapeutic activities and therapeutic exercises.

On March 5, 2012, the patient complained of right shoulder soreness and difficulty sleeping. He reported improvement with therapy but he still had ongoing pain with certain movements like lifting. Dr. noted decreased tenderness of the shoulder, increased ROM and improved muscle testing. He prescribed Flexeril and Ultracet and recommended continuing therapy as the patient showed improvement. He ordered magnetic resonance imaging (MRI) of the right shoulder.

On March 6, 2012, MRI of the right shoulder revealed the following findings: (1) Prominent superior and posterior labral tearing with an adjacent posterior paralabral cyst. (2) Supraspinatus tendinopathy with a superimposed articular surface partial tear extending 10 x 6 mm. The partial tear involved approximately 30% of the fiber thickness. (3) Mild subscapularis insertional partial tendon tearing. (4) Prominent long head biceps tendinosis. (5) Low-lying acromial process with mild/moderate hypertrophic spurring. (6) Mild reactive edema within the subacromial/subdeltoid bursa.

On March 8, 2012, the patient reported no improvement and increased pain with movement. He had diffuse tenderness over anterior and posterior shoulder and bicipital groove. Dr. recommended continuing medications and PT and referred the patient to

On March 14, 2012, M.D., evaluated the patient for shoulder pain. Examination showed positive weakness, positive impingement sign, Neer's test and Hawkin's. Dr. assessed rotator cuff syndrome, administered a steroid injection into the right shoulder, prescribed Mobic and recommended PT for impingement protocol. The patient was placed on light duty.

On March 19 and March 27, the patient attended therapy at xxxxx.

On April 11, 2012, Dr. noted the patient had joint pain and joint stiffness. The patient was noted be symptomatic despite conservative treatment. He had failed conservative management. The patient had positive Speed and O'Brien tests. Dr. assessed right shoulder impingement with labral tear, symptomatic, and recommended right shoulder arthroscopy, subacromial decompression and debridement versus repair of the superior labrum.

Per utilization dated April 20, 2012, the request for right shoulder arthroscopy and arthroscopic subacromial decompression and debridement was denied with the following rationale: *"The patient is a male who reported a work-related injury as a result of lifting to his right shoulder on xx/xx/xx. The MRI of the patient's right shoulder dated March 6, 2012, indicated prominent superior and posterior labral tearing with an adjacent posterior paralabral cyst. Additionally, supraspinatus tendinopathy with a superimposed articular surface partial tear extending 10x6 mm. The partial tear involves approximately 30% of the fiber thickness. Furthermore, there was mild subscapularis insertion partial tendon tearing, a prominent long head biceps tendinosis, and low-lying acromial process with mild-to-moderate hypertrophic spurring. Additionally, there was mild reactive edema within the subacromial-subdeltoid bursa. The clinical note dated March 20, 2012, indicates the patient received Lidocaine and Celestone injection to the right shoulder. Clinical documentation indicates the patient has not progressed with physical therapy. The patient has attended 12 sessions to date status post his*

work-related injury. The clinical note dated April 11, 2012, reports the patient has failed conservative management to this point for his injury; the patient has utilized steroid injections, physical therapy as well as NSAIDs. Upon physical exam, the patient's right shoulder revealed positive impingement sign, positive Neer, positive Hawk's, positive speed and positive O'Brien's test. The clinical note reported the patient had negative instability findings noted. The patient's strength was good with scaption. The clinical documentation lacks evidence to support the current request. Guidelines indicate criteria for surgical interventions for impingement syndrome as the following: Conservative care must be utilized 3-6 months, pain with active arc of motion 90-130 degrees and pain at night. Additionally, weak or absent abduction may demonstrate atrophy and tenderness over rotator cuff or anterior acromial area, plus MRI imaging must show positive evidence of impingement. The patient is status post his work-related injury as of xx/xx/xx. The clinical documentation did not indicate on physical exam done by the patient's primary care physician his active range of motion degrees. Additionally, there was no documentation the patient had pain at night. Furthermore, as the patient is only 2 months status post injury, the current request is not supported at this time. As such, the request for shoulder arthroscopy with subacromial decompression and debridement is non-certified."

On May 3, 2012, Dr. appealed for reconsideration of the request stating that the surgery should be approved based on the superior labral tear and associated paralabral cyst. She stated the patient's surgery should be reviewed with ODG criteria for superior labral debridement versus repair, not the acromioplasty criteria.

Per reconsideration review dated May 14, 2012, the per utilization review, the request for right shoulder arthroscopy and arthroscopic subacromial decompression and debridement was denied with the following rationale: *"The patient is a male with a reported injury on xx/xx/xx. The physical therapy evaluation note dated February 29, 2012, indicated the patient had complaints of right shoulder pain, rated at an 8/10 that was noted to be throbbing end stabbing in nature. It was noted that the patient had 160° of flexion and abduction, and 5/5 motor testing on the right upper extremity. At that time, the patient was recommended to undergo a course of physical therapy to increase upper extremity range of motion, increase strength, and decreased pain levels. It was noted that the patient was approved for 9 sessions of physical therapy to the right shoulder. The MRI of the right shoulder dated March 6, 2012, read by M.D., indicated the patient had a prominent superior-posterior labral tearing with an adjacent posterior paralabral cyst, supraspinatus tendinopathy with a superimposed articular surface partial tear extending 10x6 mm. It was noted that the partial tear involved approximately 30% of the fibroid thickness. It was also noted the patient had a low-lying acromial process with mild/moderate hypertrophic spurring. The clinical note dated April 11, 2012, indicated the patient had continued to be symptomatic despite conservative management. It was noted the patient had previously received a steroid injection, and had also been utilizing non-steroidal anti-inflammatories with no benefit. Physical examination noted the patient had a positive impingement sign, positive Neer, positive Hawk's, as well as positive speed and O'Brien's test. At that time, the patient was recommended for subacromial decompression, and debridement versus repair of superior labrum. The documentation provided indicates the patient has undergone 3 course of physical therapy that included 9 sessions, steroid*

injection, and the use of anti-inflammatories to decrease the pain symptoms in the shoulder, however has continued to be symptomatic. It was noted that an MRI indicated the patient had prominent superior-posterior labral tears with adjacent posterior paralabral cyst, as well as supraspinatus tendinopathy superimposed over the articular surface with a partial-thickness tear that involved approximately 30% of the rotator cuff attachment. I discussed the case with Audrey R. who stated the patient was greater than 3 months from date of injury and had failed NSAIDS's, subacromial injections and had MRI findings consistent with a labral tear and rotator cuff pathology. She also indicated the patient had painful arc of motion beginning at 100 degrees. However, no additional information was submitted for review noting the patient's continued conservative treatments. The guidelines state that a patient must meet specific criteria prior to undergoing a subacromial decompression. However, there is lack of documentation indicating the patient has had 3-6 months of conservative care, noting that the patient had completed 9 sessions of physical therapy. Furthermore, there is lack of documentation indicating the patient's range of motion deficits, to include pain with active arc motion from 90-130°. Given the above indications of lack of documentation to support that the patient has exhausted conservative care measures, the request cannot be substantiated. As such, the request for right shoulder arthroscopy, subacromial decompression and debridement 29626 is non-certified."

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

CLAIMANT, A MALE WITH RIGHT SHOULDER INJURY HAS POSITIVE PHYSICAL FINDINGS OF AN IMPINGEMENT SYNDROME AS WELL AS A LABRAL TEAR. MRI SCAN CONFIRMS A LABRAL TEAR WITH A LABRAL CYST. THERE IS ALSO A PARTIAL TEAR OF THE SUPRASPINATOUS TENDON. NON-OPERATIVE TREATMENT HAS INCLUDED THERAPY, MEDICATION AND INJECTION. ACCORDING TO ODG GUIDELINES TYPE II AND TYPE IV LABRAL TEARS ARE AMENDABLE TO REPAIR AND TYPE I AND TYPE III TEARS ARE FOR DEBRIDEMENT. THE PATIENT HAS BEEN OVER XXXXX SINCE HIS INJURY AND CONTINUES TO BE SYMPTOMATIC THEREFORE ACCORDING TO BOTH ODG GUIDELINES FOR A SHOULDER IMPINGEMENT AND A LABRAL INJURY THE REQUEST FOR THE SHOULDER ARTHROSCOPY, SUBACROMIAL DECOMPRESSION AND DEBRIDEMENT IS REASONABLE.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES