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Notice of Independent Review Decision

DATE OF REVIEW: March 19, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Shoulder continuous passive motion (CPM) machine x4 weeks

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

Certified, American Board of Orthopaedic Surgery
Orthopaedic Sports Medicine Subspecialty CAQ, ABOS

REVIEW OUTCOME

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Utilization reviews (02/08/12, 02/22/12)
- Office visits (04/07/11 – 01/27/12)
- PT (04/26/11 – 08/25/11)
- Diagnostics (01/13/12)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained a work-related injury to the left shoulder on xx/xx/xx. The exact mechanism of injury is not available in the records.

2011: On April 7, 2011, an orthopedic surgeon, performed left shoulder hemiarthroplasty for fracture and left shoulder open rotator cuff repair. Postoperatively, the patient did well. She was managed through her diet. She was neurovascularly intact. She was prescribed Lortab, Ambien and Toradol. She was recommended non-weightbearing with her left upper extremity. A sling was applied to her left upper extremity and she was discharged in a stable condition.

On follow-ups, noted that the patient was doing well and had no specific complaints. The discomfort was described as an aching sensation. Overall the patient indicated that things were feeling better and continuing to improve. Examination showed minimal tenderness with deep palpation at the anterior glenohumeral joint and minimal swelling at the anterior glenohumeral joint. X-rays of the left shoulder showed satisfactory alignment and fragmentation of GT. diagnosed proximal humerus fracture, rotator cuff tendonitis, rotator cuff strain and full-thickness tear of the rotator cuff, advised taking over-the-counter (OTC) non-steroidal anti-inflammatory drugs (NSAIDs), application of ice to the shoulder, using an arm immobilizer and starting physical therapy (PT).

From April 26, 2011, through July 7, 2011, the patient attended 24 sessions of PT consisting therapeutic exercises and manual therapy. A shoulder pulley was provided for home use.

On follow-ups, noted definite improvement. The discomfort was described as an aching sensation. The patient continued to have some weakness. Overall, the patient indicated that things were feeling better and she continuing to improve. recommended continuing application of ice, OTC NSAIDs and PT.

In August, noted the patient was complaining of aching, decreased function secondary to pain, tenderness, tightness in the shoulder and weakness. The patient had complaints of an intermittent aching sensation. The symptoms were localized, by pointing, to the anterior shoulder and rotator cuff region. The symptoms worsened with lifting. noted that there was no specific injury, but the symptoms gradually increased. The symptoms had gotten gradually worse with time. The patient continued to have some weakness. Examination showed minimal tenderness with deep palpation at the anterior glenohumeral joint and minimal swelling at the anterior glenohumeral joint. recommended continuing application of ice, OTC NSAIDs and PT.

In August, the patient attended seven sessions of PT consisting of therapeutic exercises, manual therapy and hot packs and cold packs.

On follow-ups, performed stress testing of the left shoulder and noted that the patient was not able to perform the abduction hold test. Scapular dystonia was positive on examination. The position of abduction with external and internal rotation caused catching sensation. Abduction with internal rotation and forward flexion with internal rotation caused pain. Stress testing of the supraspinatus caused pain. Stress of the external rotators indicated weakness. Stress testing of the supraspinatus indicated weakness. Examination of the left shoulder showed internal rotation to 20 degrees, external rotation to 20 degrees, forward flexion to 70 degrees and abduction to 60 degrees. Rotator cuff atrophy, anterior third deltoid muscle atrophy, mid-third deltoid muscle atrophy, and posterior third deltoid muscle atrophy was also seen. discussed the possibility of revision surgery as well as possible reverse total shoulder arthroplasty (TSA). He recommended continuing application of ice and OTC NSAIDs.

In December, recommended a computerized tomography (CT) scan of the left shoulder.

2012: On January 13, 2012, CT scan of the left shoulder showed: (1) Postsurgical changes of left shoulder hemiarthroplasty. (2) Small amount of contrast noted in the subacromial-subdeltoid bursa overlying the infraspinatus tendon. Focal, contrast-filled linear defect in the infraspinatus tendon measuring approximately 11 mm in AP dimension and compatible with a full-thickness tear. (3) Mild-to-moderate atrophy of the infraspinatus and teres minor muscle bellies. (4) The acromion was type II in morphology and showed anterior downsloping. (5) Moderate osteoarthritis of the acromioclavicular (AC) joint was seen.

On January 27, 2012, noted the patient was complaining of aching, decreased function secondary to pain, tenderness, tightness in the shoulder and weakness. The patient had complaints of an intermittent aching sensation. The symptoms were localized, by pointing, to the anterior shoulder and rotator cuff region. The symptoms worsened with lifting. noted that there was no specific injury, but the symptoms gradually increased. The symptoms had gotten gradually worse with time. The patient continued to have some weakness. performed stress testing of the left shoulder and noted that the patient was not able to perform the abduction hold test. Scapular dystonia was positive on examination. The position of abduction with external and internal rotation caused catching sensation. Abduction with internal rotation caused pain. Forward flexion with internal rotation caused pain. Stress testing of the supraspinatus caused pain. Stress of the external rotators indicated weakness. Stress testing of the supraspinatus indicated weakness. Examination of the left shoulder showed internal rotation to 20 degrees, external rotation to 20 degrees, forward flexion to 70 degrees and abduction to 60 degrees. Rotator cuff atrophy, anterior third deltoid muscle atrophy, mid-third deltoid muscle atrophy, and posterior third deltoid muscle atrophy was also seen. opined that the patient was a possible candidate for a reverse TSA and he would proceed with an arthroscopic debridement capsule release initially to decrease pain and improve motion. He noted that there was a significant delay from the patient's insurance company concerning PT, which was affecting her current outcome.

Per the utilization review dated February 8, 2012, the request for shoulder orthosis, AC (canvas and webbing type), prefabricated with fitting and adjustment and arthroscopy, shoulder surgical with rotator cuff repair were authorized.

Per the utilization review dated February 8, 2012, the request for home shoulder CPM x4 weeks was non-authorized based on the following rationale: *"Based on available documentation/information and evidence-based guidelines the medical necessity request for a CPM unit has not been determined. In regards to the CPM x4 weeks, the guidelines for the shoulder recommend that CPM units are not recommended."*

On February 22, 2012, an appeal for reconsideration of home shoulder CPM x4 weeks was denied based on the following rationale: *"According to the Official Disability Guidelines (ODG) regarding continuous passive motion (CPM), not recommended for the shoulder. Without any further contact from the doctor as to why the CPM unit is needed, when the guidelines for shoulder do not recommend the CPM unit in this care, an adverse determination is recommended."*

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

This claimant sustained a severe injury to the left shoulder, as described above, with subsequent hemiarthroplasty and cuff repair. It appears that the claimant's worsening trajectory of symptoms is related primarily to failure of a portion of the cuff to heal, which is not an unexpected complication after this type of surgery. Treatment for the rotator cuff deficiency is paramount, and is not served well with four weeks of CPM, which is a palliative and temporizing measure at best. ODG does not specifically address the clinical scenario herewith. However, there are insufficient alternative evidence-based sources on which to rely for an opinion in support of the CPM.

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

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**