

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Nov/14/2012

**IRO CASE #:**

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

left shoulder scope lysis and resection of adhesions MUA

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

M.D., Board Certified Orthopedic Surgery

**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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that medical necessity does exist for left shoulder scope lysis and resection of adhesions MUA.

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

ODG - Official Disability Guidelines & Treatment Guidelines

Patient registration 12/26/11

MRI left shoulder without gadolinium contrast dated 01/10/12

SOAP notes Medical Center 02/02/12

Office visit notes dated 03/27/12-10/16/12

MRI left knee without gadolinium contrast dated 04/02/12

Operative report dated 04/19/12

Physical therapy progress summary dated 06/04/12, 06/29/12, 10/01/12, and 10/15/12

EMG/NCV dated 08/08/12

MRI left shoulder with gadolinium contrast dated 08/28/12

Utilization review determination dated 09/12/12

Utilization review determination dated 10/22/12

Scheduling worksheet and consent forms dated 10/25/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who is noted to have sustained a twisting injury to the left knee on xx/xx/xx. On 04/19/12 the claimant had left knee arthroscopy with partial medial meniscectomy, microfracture medial femoral condyle, and injection of amniotic fluid. The claimant was seen in follow-up on 07/13/12 for his knee pain and he states he is still having some significant pain. He also has significant left shoulder pain. Examination of the left knee revealed no significant swelling. There was tenderness of the medial femoral condyle. Examination of the shoulder reported positive Speed's and positive impingement signs as well as tenderness over the anterior acromion and biceps tendon. MRI of the left shoulder on 01/10/12 reported AC joint mild hypertrophic degenerative changes with acute

edema/inflammation. There were findings suggestive of mild acute supraspinatus tendonitis. A MR arthrogram of the left shoulder on 08/28/12 reported findings indicative of severe acute supraspinatus tendonitis and partial tear immediately lateral to the myotendinous junction segment; moderate sized glenohumeral joint effusion; mild hypertrophic degenerative changes in the AC joint with complete effacement of the underlying subacromial fat pad/stripe. Electrodiagnostic testing performed 08/08/12 reported no evidence of left upper extremity entrapment neuropathy, and no evidence for radiculopathy or plexopathy. The claimant was seen on 08/30/12 for the left shoulder.

On examination he was noted to have very poor passive range of motion only to about 100 degrees of abduction and 20 degrees of external rotation. The claimant was recommended to undergo left shoulder arthroscopic surgery.

A request for outpatient left shoulder scope with lysis and resection of adhesions with MUA 29825 was non-certified per review dated 09/12/12. It was noted that per 08/30/12 medical report the claimant presents with left shoulder pain. Physical examination revealed limited range of motion in the left shoulder only to about 100 degrees of abduction and 20 degrees of ER. There was tenderness over the biceps tendon and weakness on forward elevation. MRI of the left shoulder dated 08/28/12 revealed severe acute tendonitis and partial tear immediately lateral to the myotendinous junction segment, moderate sized glenohumeral joint effusion, mild hypertrophic degenerative changes in the acromioclavicular joint with complete effacement of the underlying subacromial fat pad/stripe, there is mild to moderate sized joint effusion with the majority of the fluid in the glenohumeral joint space axillary recess. It was noted that there was no documentation of failure of conservative treatment (physical therapy and NSAIDs) and range of motion that remained significantly restricted (abduction less than 90). Therefore, medical necessity has not been established.

The claimant was seen in follow-up on 10/16/12. It was noted that the claimant has failed all conservative treatments including injections, rest, and physical therapy to the left shoulder. Examination reported flexion to about 105 degrees, 50 degrees of extension, 80 degrees of abduction, 80 degrees of internal rotation, and 38 degrees of external rotation. The claimant was noted to continue with severe pain with no improvement from physical therapy or injections.

A reconsideration request for left shoulder scope with lysis and resection of adhesions with MUA 29825 was non-certified per review dated 10/22/12. It was noted that clinical documentation submitted for review indicates that the claimant continues to present with complaints of the left shoulder. After review of the documentation, there is a lack of evidence that the claimant has participated in active supervised therapeutic interventions for the left shoulder. The file included physical therapy notes, but this addressed the claimant's left knee and lumbar spine. Without documentation of attempted physical therapy modalities for the shoulder, the request is not supported at this time.

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

The claimant was noted to have sustained a twisting injury to the left knee resulting in chondral damage and meniscal tear. The claimant underwent left knee arthroscopy on 04/19/12. The records indicate that the claimant participated in physical therapy before and after surgery. The claimant also complained of left shoulder pain, and MRI with contrast of the left shoulder dated 08/28/12 revealed severe acute tendonitis of the supraspinatus tendon with partial tear immediately lateral to the myotendinous junction segment, with moderate sized glenohumeral joint diffusion and mild hypertrophic degenerative changes in the AC joint with complete effacement of the underlying subacromial fat pad/stripe. According to an office note dated 10/16/12, the claimant failed conservative treatment including injections, rest, and physical therapy to the left shoulder. It appears the patient underwent a cortisone injection to the left shoulder on 07/18/12, which was not helpful. Therapy progress notes indicate that the patient failed to improve with at least 10 physical therapy visits and home exercise program. Given the current clinical data, it is the opinion of the reviewer that medical necessity does exist for left shoulder scope lysis and resection of adhesions MUA. Upon independent review,

the reviewer finds that the previous adverse determination/adverse determinations should be overturned.

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

ACOEM-AMERICA 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)