

I-Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/20/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

left shoulder diagnostic scope and debridement, SAD, RCR 23120, 29822, 29826-59, 23420, 29823, 29825

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

M.D., Board Certified Orthopedic Surgeon (Joint)

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. The reviewer finds medical necessity cannot be established for the requested left shoulder diagnostic scope and debridement, SAD, RCR 23120, 29822, 29826-59, 23420, 29823, 29825.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

X-ray left shoulder five views 03/30/12

General orthopedic clinical notes 03/30/12-09/07/12

SOAP physical therapy notes 05/02/12

Letter of medical necessity 06/05/12

Operative report 06/07/12

Utilization review determination 10/05/12

Utilization review determination 10/24/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whose date of injury is xx/xx/xx. Records indicate that the claimant was injured when he fell off a ladder and an object that he had with him fell on the top part of his right shoulder. He has had right shoulder pain since the time of the injury. Records indicate that the claimant has had three surgeries with the last surgery in 12/11. The claimant underwent examination and manipulation under anesthesia of the left shoulder with injection of local anesthetic into the left shoulder joint performed on 06/07/12. Orthopedic clinical note dated 07/13/12 noted that the claimant states he continues to have pain involving the left shoulder and limited motion despite rest, physical therapy, rehab, and dynamic splinting. Examination on 07/13/12 noted the claimant to be 5'8" tall and 125 pounds. Left upper extremity had limited painful range of motion. AATE was 150 degrees, and very painful past 100 degrees. There was tenderness over the Mumford incision. Neer and Hawkins impingement signs were positive. There was 4+/5 strength on drop arm test. Speed test was painful. There was equivocal O'Brien test. There was limited internal and

external rotation, as well as secondary to discomfort at extreme range. The claimant was subsequently seen on 09/07/12 with continued shoulder pain and limited range of motion. Examination at this time reported left upper extremity pain with range of motion in the shoulder. There was passive range of motion of forward flexion to 80 degrees and abduction to 80 degrees. With active range of motion, there was forward flexion of 30 degrees and abduction of 45 degrees. Active assisted range of motion was 135 degrees of forward flexion and abduction of 140 degrees. There were positive Neer and Hawkins impingement signs. There was 4/5 strength on drop arm test. There was painful Speed test. There was equivocal O'Brien, with limited internal and external rotation. No radiology report was submitted for review, but MRI was noted to show recurrent tear of the interior fibers at the humeral attachment of the rotator cuff two times two centimeters.

A request for outpatient surgery left shoulder diagnostic scope and debridement, subacromial decompression, and rotator cuff repair was non-certified per review dated 10/05/12, noting that physical examination from 09/07/12 was not provided for review. There was no documented range of motion of the left shoulder. Despite MRI evaluation in 07/12, which was noted to show recurrent full thickness rotator cuff tear, revision of rotator cuff is inferior to that of primary repair according to guidelines. Selection criteria should include claimants with an intact deltoid origin, good quality rotator cuff tissue, and pre-operative evaluation of the ability to elevate the arm to 90 degrees with only one prior procedure. The claimant has had two prior shoulder arthroscopies with one documented rotator cuff repair. Most recent physical examination did not include active range of motion of the left shoulder. The request for outpatient left shoulder diagnostic scope and debridement, subacromial decompression, and rotator cuff repair was non-certified.

An appeal request for left shoulder diagnostic scope/debridement, subacromial decompression, and rotator cuff repair was non-certified per review dated 10/24/12. The reviewer noted that Official Disability Guidelines state rotator cuff repair is indicated for significant tears and impaired activities by causing weakness of arm elevation and rotation, particularly acutely in younger workers. There should be documentation of failure of conservative care of three to six months plus subjective clinical findings to include pain with active arc of motion 90 degrees and pain at night, plus objective clinical findings to include weak or absent abduction; may also demonstrate atrophy and tenderness over the rotator cuff or anterior acromial area and a positive impingement sign with temporary relief of pain with anesthetic injection, plus imaging clinical findings to include conventional x-rays and MRI showing positive evidence of a deficit in the rotator cuff. The request previously was denied, as there was no documented range of motion of the left shoulder. The determination indicated that, despite MRI evaluation in 07/12, which objectified the current full thickness rotator cuff tear, revision of the rotator cuff is inferior to that of primary repair. It was again noted that the claimant has had two prior shoulder arthroscopies with one documented rotator cuff repair. Upon discussion with designated representative, it was stated that the official MRI report will be faxed over demonstrating rotator cuff tear. It was further stated that this was not a recurrent tear and the previous surgery was for labral repair. Additional imaging studies were received and reviewed, but most recent official MRI was not submitted for review to indicate a recurrent rotator cuff tear. Given the above information, the request for appeal of left shoulder diagnostic scope and debridement, subacromial decompression, and rotator cuff repair was non-certified.

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

The claimant is noted to have sustained injury to the left shoulder when he fell from a ladder and an object fell on top of the left shoulder. According to the records, the claimant has had three previous surgeries with two scopes, a labral repair, and an open rotator cuff repair. The claimant has also undergone manipulation under anesthesia. He continues to complain of left shoulder pain. According to orthopedic clinical note dated 09/07/12, an MRI shows recurrent tear of the rotator cuff; however, no radiology report was submitted for review. On examination the claimant was noted to have pain with range of motion. There was limited range of motion with active forward flexion of 30 degrees and abduction of 45 degrees; passive range of forward flexion to 80 degrees and abduction to 80 degrees; active assisted

range of motion to 135 degrees of forward flexion and abduction of 140 degrees. Impingement signs were positive, and strength was 4/5 on drop arm test, with painful Speed test. While it appears that a repeat left shoulder arthroscopy may be indicated with possible subacromial decompression and rotator cuff repair, without further clinical data including official MRI report as described in office note from 09/07/12, the reviewer finds medical necessity cannot be established for the requested left shoulder diagnostic scope and debridement, SAD, RCR 23120, 29822, 29826-59, 23420, 29823, 29825.

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)