

# Applied Assessments LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Nov/06/2012

### IRO CASE #:

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

Left Shoulder Diagnostic Scope

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

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.**

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Cover sheet and working documents

MRI left shoulder dated 09/14/11

MRI cervical spine 09/14/11

Handwritten encounter notes 09/11

Office visit note dated 10/03/11

Report of medical evaluation dated 06/28/12

History and physical dated 08/16/12

Handwritten note 08/30/12

Preauthorization request 09/17/12

Utilization review determination dated 09/21/12

Utilization review determination dated 10/12/12

### PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who reportedly was injured on xx/xx/xx while moving tables when she felt a sharp pain in the left shoulder and neck. MRI of the cervical spine dated 09/14/11 revealed minimal disc bulges from C3-4 through C5-6 with no significant central canal or foraminal narrowing. MRI of the left shoulder on 09/14/11 revealed marked thickening of the intraarticular biceps tendon with associated increased signal. Findings are compatible with tenosynovitis or tendinosis/partial tear of the biceps tendon. There was also evidence of partial tear/tendinosis tendinitis tendinosis of the supraspinatus tendon. Records indicate the claimant was treated with physical therapy. She also underwent subacromial injection of the

left shoulder. Claimant underwent designated doctor evaluation on 06/28/12. Examination of the shoulder at that time revealed exaggerated pain upon palpation. There was no swelling, erythema or deformity of the shoulder joint. Range of motion for all planes, especially internal rotation and abduction were markedly decreased, but seemed exaggerated. Near impingement was positive, Hawkins' test was negative. Claimant was determined to have reached maximum medical improvement as of 06/28/12 with a whole with a 4% whole person impairment rating. It was noted that the claimant showed no diagnosis of related impairment for the right or left shoulder that would be ratable. The claimant was seen on 08/16/12 with complaints of left shoulder and neck pain. Claimant stated she was she had been seen in orthopedics and was given medications and recommended physical therapy, but still has significant left shoulder pain and limitation of range of motion. Office note dated 08/30/12 reported that the claimant has had physical therapy and cortisone injection without relief. Examination to left shoulder reported active range of motion 0-70 degrees; and passive range of motion 0-80 degrees. There was tenderness of the subacromial space; tenderness to proximal humerus; 3/5 rotator cuff strength; positive drop sign.

A request for diagnostic shoulder arthroscopy was reviewed on 09/21/12 and the request was non-authorized as medically necessary. The reviewer noted that following peer to peer discussion, the MRI study does not document any significant acute findings to support the medical necessity of the left shoulder diagnostic arthroscopy, particularly with electrodiagnostic studies documenting evidence of an upper trunk injury of the brachial plexus.

A reconsideration request for diagnostic shoulder arthroscopy was reviewed on 10/12/12 and request was non-certified as medically necessary. Reviewer noted that the claimant had mild decreased active and passive range of motion upon evaluation in 2011. Subsequent evaluation was noted to lack any was noted to lack any past history of neurological assessment only noted to decreased shoulder range of motion, and did not even specify the specific motions tested. Clinical record is incomplete and inadequate for any neurological examination, does not report reflex sensation, reflexes, sensation or muscle atrophy. It was noted after peer discussion with the only diagnosis that would be supported is adhesive capsulitis.

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

Based on the clinical data provided, the proposed left shoulder diagnostic scope is not recommended as medically necessary. The claimant is noted to have sustained an injury to the neck and left shoulder while moving heavy tables. MRI of the left shoulder on 09/14/11 revealed marked thickening of the interarticular biceps tendon with increased signal, compatible with tendinosis/partial tear of the biceps tendon. There were findings compatible with mild tendinosis/partial tear of the supraspinatus tendon, with no tendon retraction or muscle atrophy seen. Records indicate the claimant was treated in 2011 with therapy and injections without significant improvement. Per designated doctor evaluation the claimant has reached maximum medical improvement as of 06/28/12, with no ratable impairment to the right or left shoulder. The designated doctor also noted that there were exaggerated symptoms with pain upon palpation of the shoulder, as well as exaggerated limitations on range of motion. As noted on previous reviews, the examination on 08/30/12 reported active versus passive range of motion 0-70 versus 0-80; however, there's no indication as to if this was as to what plane of motion was measured. Other than a subacromial injection on 09/10/12 there is no documentation of recent conservative treatment to the left shoulder. It was noted the claimant previously had physical therapy and cortisone injections, but it appears that this was done in 2011. Given the current clinical data, the request for left shoulder diagnostic scope is not recommended as medically necessary, and previous denials are upheld.

**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)