



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision

Date notice sent to all parties: 11/25/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left shoulder arthroscopic rotator cuff repair, lysis of adhesions, and subacromial decompression

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

Board Certified in 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 of the health care services in dispute.

Left shoulder arthroscopic rotator cuff repair, lysis of adhesions, and subacromial decompression - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Report dated 05/02/13
Bilateral shoulder x-rays dated 05/02/13
Report dated 05/07/13

Work Injury Accident Details dated 05/07/13
Reports from provider, dated 05/17/13, 05/20/13, 05/22/13, and 06/26/13
Physical therapy evaluation dated 05/14/13
Physical therapy notes dated 05/22/13, 05/24/13, 05/28/13, 05/30/13, 05/31/13, 06/03/13, 06/06/13, 06/07/13, 06/10/13, 06/13/13, 06/17/13, 06/19/13, 06/21/13, and 06/26/13
Left shoulder MRI dated 06/13/13
Reports dated 07/29/13, 09/04/13, and 09/09/13
Preauthorization request dated 09/20/13
Preauthorization Notices dated 09/20/13 and 10/15/13
Adverse determinations from Mutual dated 10/11/13 and 10/16/13
Letter from Mutual addressed to Professional Associates dated 11/12/13
Undated Preauthorization Appeal
The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

On 05/02/13, examined the patient. He had pain in both his shoulders, but the left was more painful than the right. This was an essentially illegible note. X-rays of the bilateral shoulders on 05/02/13 were normal, except for AC joint arthrosis bilaterally compatible with degenerative changes. On 05/07/13, he noted he injured his bilateral shoulders stacking an illegible item. Abduction was decreased on the left. Flexeril and Naproxen were prescribed and he was referred for therapy. On 05/17/13, evaluated the patient. He felt sudden, sharp pain in both shoulders. He had apprehension in the left shoulder, as well as bilateral tenderness. He had bilateral trapezius and deltoid tenderness. The diagnoses were rotator cuff, bilateral shoulder sprain/strain, and muscle spasm. Therapy was recommended and he was taken off of work for one week. On 05/22/13, it was noted the patient had not had any therapy at that time and moderate to severe pain in the left shoulder and mild to moderate pain in the right shoulder. He was tender in the bilateral shoulders, but there were limited in range of motion and strength. MRIs were recommended and he was again referred to therapy. The patient attended therapy from 05/22/13 through 06/26/13 for a total of 14 visits. He received therapeutic exercises. An MRI of the left shoulder was performed on 06/13/13 and interpreted. There was mild tendinosis and partial thickness articular sided tear of the infraspinatus tendon insertion involving great than 50% tendon thickness that measured 8 mm without retraction. There was mild tendinosis of the subscapularis tendon with a low grade interstitial tear near the tendon insertion. There was mild tendinosis and mild articular surface fraying of the supraspinatus tendon without a measurable tear. Mild tendinosis of the intrarticular long head of the biceps tendon was noted with a longitudinal interstitial tear extending to the biceps tendon anchor. Degeneration of the superior labrum without a tear was noted, along with moderate arthrosis of the AC joint. There was no evidence of mass effect on the supraspinatus. On 06/26/13, reviewed the MRI. He was referred to an orthopedist. examined the patient on 07/29/13. He presented for follow-up and an injection for the left shoulder, which

was unchanged. There was tenderness of the AC joint and greater tuberosity in the left shoulder, as well as the supraspinatus and infraspinatus. He had limited range of motion and normal strength bilaterally. A left shoulder Cortisone injection was performed at that time for the diagnoses of sprain/strains of the shoulder and upper arm and rotator cuff capsule. On 09/04/13, reexamined the patient. His examination was essentially unchanged and there was no documentation regarding his response to the steroid injection. The patient returned on 09/09/13. His current medications were Glyburide, Lipofen, Lisinopril, Simvastatin, and Victoza. He stated his pain had gotten worse in the left shoulder since the previous visit. He felt a constant, sharp burning pain. He had still had tenderness of the AC joint, greater tuberosity, infraspinatus, and supraspinatus. Range of motion was limited and strength was 5/5 throughout. His reflexes were normal. Left shoulder arthroscopy was recommended. He also reported the Cortisone injection only helped for two days. He also noted to still have right shoulder pain. On 09/20/13, requested left shoulder surgery. On 09/20/13 and 10/15/13, provided preauthorization notices, noting an adverse determination had been made for the requested left shoulder surgery. On 10/11/13 and 10/16/13, also provided notices of adverse determination for the requested left shoulder arthroscopic rotator cuff repair, lysis of adhesions, and subacromial decompression.

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

The patient is a male who was reported to have sustained a work related injury on xx/xx/xx. The patient reported bilateral shoulder pain, left greater than right, and noted that he “over did it.” A lot of the initial medical documentation was handwritten and illegible. Plain x-rays documented evidence of acromioclavicular arthrosis bilaterally. A left shoulder MRI on 06/13/13 revealed rotator cuff tendonitis, no complete tears, biceps tendonitis with interstitial tearing, a degenerative labrum, and moderate acromioclavicular arthrosis. The patient eventually was evaluated by an orthopedic surgeon, who performed a steroid injection. The site of the injection, whether it was glenohumeral or subacromial, was not delineated in the record. denied a request on initial review on 09/20/13. His denial was upheld on reconsideration/appeal on 10/15/13. Both reviewers attempted a peer-to-Peer, without success, with the requesting physician. Both reviewers’ basis for their decisions was that the request did not meet the ODG criteria.

The ODG note that authors conclude that primary subacromial impingement is largely an intrinsic degenerative condition rather than an extrinsic mechanical disorder. (Henkus 2009) A recent randomized control study concluded that arthroscopic acromioplasty provides no clinical important effects over a structured and supervised exercise program alone in terms of subjective outcomes or cost effectiveness when measured at 24 months and that structured exercise treatment should be the basis for treatment of shoulder impingement with operative treatment offered judiciously. (Ketola 2009)

The ODG for surgery, in particular acromioplasty, notes that for the diagnosis of acromial impingement syndrome that 80% of patients will get better without surgery. The criteria include:

- 1) Conservative Care: Recommend three to six months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed towards gaining full range of motion, which requires both stretching and strengthening to balance the musculature. PLUS
- 2) Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees AND Pain at night. PLUS
- 3) Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy AND Tenderness over the rotator cuff or anterior acromial area AND positive impingement sign and temporary relief of pain with anesthetic injection. PLUS
- 4) Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement. (Washington 2002)

It should be noted that this patient clearly has not had continuous treatment for six months as documented in the reviewed material. There is little information regarding his active arc of motion from 90 to 130 degrees and whether this, indeed, is represented by a painful arc. In addition, there is no documentation that supports weak or absent abduction or significant atrophy to be present. It should be noted that this condition is a continuum with other rotator cuff conditions, including rotator cuff syndrome and rotator cuff tendonitis. Arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff (Gartsman 2004). The physical therapy notes do not clearly document a formal supervised and structured exercise program as required by the ODG. Therefore, the requested left shoulder arthroscopy with rotator cuff repair, lysis of adhesions, and subacromial decompression is not medically necessary, reasonable, or supported by the evidence based ODG at this time and the previous adverse determinations should be upheld.

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

- ACOEM- AMERICAN 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)**