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Notice of Independent Review Decision

Date: October 31, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left shoulder arthroscopic rotator cuff repair and decompression

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

REVIEW OUTCOME:

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

☒ Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Utilization reviews (09/04/13 – 09/27/13)

- Office visits (05/13/13 – 09/20/13)
- Diagnostic (05/21/13)
- Utilization reviews (09/04/13 – 09/27/13)

- Diagnostic (05/21/13)
- Office visits (08/09/13 – 09/20/13)
- Utilization reviews (09/04/13 – 10/03/13)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is male who on xx/xx/xx, felt a rip in his left shoulder.

Per report dated May 15, 2013, recommended magnetic resonance imaging (MRI) of the left shoulder. Diagnosis listed were sprain of the shoulder and pain in limb.

On May 21, 2013, MRI of the left shoulder showed the following findings: (1) Type II acromion process with mild anterior tilt and small inferior acromial spur. Mild lateral arch stenosis and mild inflammatory changes in the subacromial/subdeltoid bursa. (2) There was supraspinatus tendinosis and a vertical supraspinatus tear at the musculotendinous junction. Tear communicated with the bursal surface and possibly separated from the articular surface by a thin margin. (3) Small linear fluid signal along the infraspinatus tendon possibly representing a ganglion cyst or longitudinal tear. (4) A 6-mm subcortical cyst at the lateral margin of the bicipital groove.

Per report dated May 22, 2013, assessed sprain of shoulder/arm, pain in limb and other specified disorders of bursae and tendons in shoulder region.

On July 17, 2013, an orthopedic surgeon, noted that the patient had not improved. Diagnosis was partial tear of the rotator cuff. The patient was referred and was placed on regular work without restrictions.

On August 9, 2013, evaluated the patient for left shoulder pain, radiating from the shoulder down the upper arm. The patient had constant, dull aching with intermittent sharp pain when lifting and certain movements, weakness, decreased range of motion (ROM) and tingling. Previous treatment included physical therapy (PT) and cortisone injection. Examination of the left shoulder showed painful arc from 90 to 130 degrees, positive impingement sign, supraspinatus isolation test, Neer impingement sign and Hawkins impingement sign. Motor strength of the rotator cuff muscles was 4/5. X-rays were obtained which showed Bigliani type II acromion. reviewed the MRI findings. The patient had tried injections and therapy but with no improvement. assessed sprain/strain of the rotator cuff (capsule) and other affections of shoulder region, not elsewhere classified. He recommended left shoulder rotator cuff repair and subacromial decompression.

Per utilization review dated September 4, 2013, the request for left shoulder arthroscopic rotator cuff repair and decompression with postoperative durable medical equipment (DME), abduction sling 26827, 29826 and L3670 was denied with the following rationale: *"The request for left shoulder rotator cuff repair and subacromial decompression with postoperative DME sling is non-certified. The MRI submitted for review indicated the patient does have rotator cuff tear and downsloping acromion. The patient has physical exam findings consistent with impingement and rotator cuff tear. The one note submitted for review mentioned the patient had been previously treated with physical therapy and cortisone injection. However, it is unclear as to the dates of service, duration, and efficacy of physical therapy. It is also unclear as to the date of service and efficacy of the cortisone injection. Furthermore, Official Disability Guidelines only recommend postoperative abduction slings for patients undergoing open repair of a massive rotator cuff tear. The MRI does not reveal evidence of a massive tear and the*

patient is proposed for arthroscopic surgery. Given the above, the request was non-certified."

On September 20, 2013, noted that the patient's shoulder was getting worse and the pain had started radiating down into the biceps. Examination of the left shoulder showed painless full ROM and painful arc from 90 to 130 degrees, positive impingement sign, supraspinatus isolation test, Neer impingement sign and Hawkins impingement sign. Motor strength was 4/5 of the rotator cuff muscles. noted the patient had failed home therapy and did not want any injection. He recommended left shoulder rotator cuff repair, subacromial decompression and extensive debridement.

Per utilization review dated September 27, 2013, the request for outpatient surgery for the left shoulder, CPT code 29822 added to the reconsideration for an additional UR number 49152 was denied with the following rationale: "*The request for outpatient surgery for the left shoulder, CPT code 29822 in addition to UR 49152 is non-certified. The documentation submitted for review elaborates the patient complaining of left shoulder pain with associated functional deficits. A concurrent request for a left shoulder arthroscopic rotator cuff repair and decompression is noted. Given that the additional utilization review request resulted in a lack of certification, the additional request for an arthroscopic debridement is rendered non-certified."*

Per reconsideration review dated October 3, 2013, the request for reconsideration for left shoulder arthroscopic rotator cuff repair, decompression with postoperative 29827, 29826 and L3670 was denied with the following rationale: *"Per the physician advisor the requested services have been denied as not medically necessary and appropriate. The request for reconsideration for a. left shoulder arthroscopic rotator cuff repair and decompression is non-certified. The documentation submitted for review elaborates the patient complaining of left shoulder pain with associated range of motion and strength deficits. The Official Disability Guidelines recommend a rotator cuff repair provided the patient meets specific criteria to include completion of a three-month course of physical therapy addressing the left shoulder complaints. There is mention in the clinical notes regarding the patient's previous involvement with physical therapy as well as a home exercise program. However, no dates or the number of sessions were included in the documentation. Given this, the request does not meet guideline recommendations."*

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

A review of the records provided supports the claimant is a male who felt a rip in his left shoulder xx/xx/xx. The claimant saw 05/15/13 and recommended MRI of the shoulder. The claimant was diagnosed with sprain/strain. The MRI 05/21/13 showed tendinosis, bursal tear of the supraspinatus tendon was not thought to be full thickness, degenerative changes were noted and they recommended considering arthroscopy. The claimant saw 02/17/13 and referred and continue

full duty work. evaluated the claimant 08/09/13 the claimant was previously treated with physical therapy, cortisone injection, had pain, positive impingement testing. He recommended left shoulder rotator cuff repair and subacromial decompression. The claimant had failed physical therapy and did not want another cortisone injection.

The claimant is now xx months status post the reported injury and reports persistent pain and weakness in the shoulder consistent with rotator cuff tear and impingement. The claimant previously failed conservative care with injection therapy, activity modifications and physical therapy. Consistent with evidence based medicine and the Official Disability Guidelines I would approve arthroscopic evaluation, repair and decompression as medically necessary.

Should further records, diagnostics or peer review become available I will be happy to take this into consideration.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**