

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: January 30, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder Arthroscopy with Debridement, Distal Claviclectomy, SAD, Rotator Cuff Repair

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

This physician is Board Certified Orthopedic Surgeon with over 40 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

09-07-12: History and Physical

09-12-12: Radiology Report: MRI Right Shoulder without contrast

09-19-12: Orders Note

10-16-12: UR performed

10-22-12: Initial Evaluation

10-24-12: Progress/Treatment Note

10-26-12: Progress/Treatment Note

10-29-12: Progress/Treatment Note

10-31-12: Progress/Treatment Note

11-02-12: Progress/Treatment Note

11-05-12: Progress/Treatment Note

11-05-12: UR performed

11-07-12: Progress/Treatment Note

11-09-12: Progress/Treatment Note
11-12-12: Progress/Treatment Note
11-14-12: Progress/Treatment Note
11-16-12: Progress/Treatment Note
11-19-12: Discharge Summary

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured at work on xx/xx/xx. He experienced a hyperextension injury and reported immediate pain to the right shoulder.

09-07-12: History and Physical. Claimant stated right shoulder pain with over head activity, sleeping on affected side, work duties, lifting, and everyday use. The pain is relieved by rest, avoiding offending activity and injections. The pain radiates into upper arm in the right upper extremity and right had numbness and swelling. He states he feels a pulling to his neck that goes through his shoulder. Recent Care: Evaluation revealed impingement. Claimant was treated with injection and given HEP. Claimant stated that the injection only helped for a week and was referred for MRI. Physical Examination: Right Upper Extremity: Shoulder: moderate tenderness to deep palpation; limited ROM with pain at extremes of passive motion, poor active motion with resistance; external rotator strength 5/5; positive impingement sign, positive internal rotation sign. Assessment: Right rotator cuff tear (Traumatic) 840.4. Plan: shoulder x-rays: internal/external rotation 73030; MRI right shoulder for rct.

09-12-12: Radiology Report: MRI Right Shoulder without contrast. Impression: 1. Tendinopathy and partial-thickness tears involving the supraspinatus tendon without evidence of muscular atrophy or significant retraction changes. Tiny focus of fluid signal posterior mid portion of the supraspinatus tendon raises suspicion for a possible tiny occult full-thickness tear of the supraspinatus tendon. 2. Infraspinatus tendon intact, although there is fluid signal which tracks along the undersurface into the infraspinatus muscle which may be related to an element of tendinopathy versus injury and partial muscle tear. 3. Tendinopathy and partial-thickness tears of the subscapularis tendon. 4. Degenerative changes and apparent postoperative changes as described. 5. Suboptimal evaluation of the labrum but there is evidence of some signal at the superior labrum suspicious for possible labral tear.

10-16-12: UR performed. Reason for denial: The request for right shoulder arthroscopy with debridement, distal claviclectomy, SAD, rotator cuff repair is not certified. The guidelines indicate that for rotator cuff repair or acromioplasty conservative care is recommended for three to six months. Three months if treatment has been continuous, six months if treatment has been intermittent. The medical documentation provided for review documents the claimant has undergone a home exercise program and corticoid steroid injection provided some relief. There was no indication if this has been on an intermittent or continuous basis or if there has been any objective clinical findings which demonstrated weak or absent abduction, tenderness over the rotator cuff, or anterior acromial area, positive impingement sign, temporary relief after diagnostic

injections. The medical documentation provided for review documents that the claimant has ongoing right shoulder pain with overhead activity on the effected side and with working, lifting and everyday use. There were no subjective complaints of pain with arch motion to 90-130 degrees or pain at night. The physical examination that was provided for review does not document weak or absent abduction. There is a positive impingement sign. The claimant did receive temporary relief with an anesthetic injection. There was a negative drop arm sign and motor strength and external rotator was 5/5 and no instability on provocative testing. Based upon the medical documentation provided for review and the peer reviewed evidenced based guidelines and without documentation that all lower levels of conservative care have been exhausted either continuously or intermittent basis between three to six months including physical therapy directed at gaining full range of motion plus subjective clinical findings such as pain with range of motion 90-130 degrees, complaints of pain at night, weak or absent abduction the request for right shoulder arthroscopy, debridement, distal claviclectomy, SAD, rotator cuff repair is not medically supported by the guidelines.

10-22-12: Initial Evaluation. Problems: Moderate to severe pain and limitations during and/or after a specific IADL affecting performance; moderate to severe pain and limitation in a specific work activity affecting performance; moderate to severe pain and limitation in a specific recreational activity affecting performance. Pain in right shoulder: at rest 3/10; with activity 9/10; sharp and radiating. Assessment: Claimant to benefit from estim, hot pack, ultrasound, joint mobilization, P/AROM exercises, iontophoresis, kinetic exercises and home programs to reach the above established goals. Duration of OT: 6 weeks.

11-05-12: UR performed. Reason for denial: Right shoulder arthroscopy, distal claviclectomy, subacrominal decompression, rotator cuff repair is not indicated in spite of the injury date January 3, 2012. He has another six weeks of physical therapy. He has had two injections. He still has good strength. Peer to peer discussion who had interpreted 75% partial thickness rotator cuff tear. Typically in partial tears the natural history is not well understood, but conservative care for at least three months is reasonable, appropriate and consistent with ODG. Request non-certified.

11-19-12: Discharge Summary. Medical Diagnosis: Shoulder arthropathy specified other 716.81; Shoulder rupture complete rotator cuff, 727.61. Assessment: Claimant continues to report less overall pain with strengthening tasks. Claimant stated he has no pain with use of arm. Claimant continues to have some weakness but has been given home exercise programs to continue with. Will discharge with all goals met. Final Instructions: Claimant and family were given a written 2 times daily program to maintain current level of function.

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

The previous adverse determinations are upheld and agreed upon. After reviewing the medical records and documentation provided for this case, the

request for right shoulder arthroscopy with debridement with rotator cuff repair as well as SAD is not medically necessary per ODG guidelines as previously determined. On 11/19/12 claimant was discharged with all goals met and stated that the claimant has no complaints of pain with the use of the right arm therefore does not warrant surgical intervention. Therefore, the request for Right Shoulder Arthroscopy with Debridement, Distal Claviclectomy, SAD, Rotator Cuff Repair is denied.

Per ODG:

<p>Surgery for rotator cuff repair</p>	<p>ODG Indications for Surgery™ -- Rotator cuff repair: Criteria for rotator cuff repair with diagnosis of <u>full thickness</u> rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out: 1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS 2. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS 3. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff. Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of <u>partial thickness</u> rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.) 1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, 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 (Tenderness over the greater tuberosity is common in acute cases.) PLUS 3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). 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 deficit in rotator cuff. (Washington, 2002) For average hospital LOS if criteria are met, see Hospital length of stay (LOS).</p>
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<p>Partial claviclectomy (Mumford procedure)</p>	<p>ODG Indications for Surgery™ -- Partial claviclectomy: Criteria for <u>partial claviclectomy</u> (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint: 1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS 2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS 3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS 4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation.</p>
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Surgery for impingement syndrome	<p>ODG Indications for Surgery™ -- Acromioplasty: Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.) 1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, 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 rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). 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)</p>
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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)