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Notice of Independent Review Decision

DATE: June 24, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient examination under anesthesia, arthroscopy with debridement, subacromial decompression, Mumford and rotator cuff repair for the right shoulder.

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

The reviewer is certified by the American Board of Orthopedic Surgeons with 42 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:

03/06/13, 04/24/13: Office visit
03/11/13: MRI Right Shoulder report interpreted with Open MRI
04/03/13: Office visit
04/11/13: UR performed
04/15/13: TASB Notes
04/18/13: Family Medicine In-Clinic Communication
05/08/13: General orthopaedic clinic note
05/13/13: Preauthorization request
05/13/13: UR performed
05/16/13: Adverse determination letter
05/23/13: Reconsideration request by
05/23/13: Appeal/reconsideration Acknowledgement Letter
05/23/13: UR performed
05/24/13: Notes
05/31/13: Appeal Determination Denial

06/10/13: Prospective Review (IRO) Response

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his right shoulder when he was thrown from the back to the front when the driver slammed on the brakes while working on xx/xx/xx.

The claimant was evaluated for right shoulder pain. It was noted that he had difficulty with ADLs, any overhead reaching or pulling. He complained of numbness and a tingling sensation in the right hand. On physical exam, he had decreased range of motion on abduction and adduction of the right shoulder. He was able to flex/extend, but painful. He had good pulses. Capillary refill was brisk. There were no sensory deficits. He was given Norco and scheduled for therapy.

03/11/13: MRI Right Shoulder report. IMPRESSION: Moderate subacromial/subdeltoid bursitis. Supraspinatus tendinosis with a tiny 2 mm insertional partial tear at the humeral attachment. Findings may represent a concealed interstitial tear occurring at the footprint attachment. There is no full-thickness tendon tear. Infraspinatus tendinosis.

04/24/13: The claimant was evaluated for right shoulder pain. It was noted that he had been receiving physical therapy. He reported no change in his shoulder pain. It was noted that he had difficulty with right shoulder abduction. He reported pain with catching and popping. It was noted that he had been doing light duty at work. On physical exam, he had decreased range of motion of right shoulder abduction and adduction.

05/08/13: The claimant was evaluated for right shoulder pain. It was noted that he had attended physical therapy for six weeks and was still having quite a bit of pain. He denied any current paresthesias. It was noted that his arm was numb for a couple of days, but that had been resolved. He relates occasional painful popping and achiness, especially when he used his arm away from his body or reaching behind him. On physical exam, the right shoulder had AATE 155 degrees. Positive Neer and Hawkins impingement sign. It was noted that he could barely reach his wallet and ER to top of his head, both painful as well. Positive O'Brien test. Tender over the AC joint. Weakness with Speed test. 4+/5 strength and pain with drop arm test. Negative anterior apprehension and posterior apprehension. Negative relocation sign. Negative relocation test. X-rays of the right shoulder revealed no acute bony abnormalities. MRI films were not available, but report revealed signal changes in the rotator cuff compatible with partial tear. Films showed intrasubstance tear of the distal supraspinatus tendon along with signal changes in the glenoid labrum as well. He was to bring MRI films for review and continue self rehab exercises.

05/13/13: UR performed. RATIONALE: The ODG indicates that "80% of patients will get better without surgery." 3-6 months conservative treatment is recommended plus diagnostic/anesthetic injection. The patient does not meet the

ODG criteria for surgery for partial thickness tear of the rotator cuff. He has had limited conservative treatment. Based on discussion representative, the requested procedures are denied at the current time.

05/23/13: UR performed. RATIONALE: Additional records were not provided for review. The claimant was reported to have been treated with activity modification, oral medications, and physical therapy. The guidelines indicate lower levels of care must occur for three to six months and treatment must be directed toward gaining full range of motion. There must be subjective complaints, such as pain at arc of motion from 90-130 degrees, pain at night, objective findings of tenderness over the rotator cuff or anterior acromial area, positive impingement sign, and temporary relief of pain with an anesthetic injection. For acromioplasty there must also be evidence of impingement on imaging studies. There was no documentation the claimant had undergone a corticosteroid injection that provided any temporary relief prior to a subacromial decompression. The request for an appeal of a right shoulder EUA arthroscopy with debridement, subacromial decompression, Mumford, and rotator cuff repair is not certified.

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

The previous adverse decisions are upheld. Official Disability Guidelines recommend 3-6 months of conservative care. No documentation has been submitted to indicate that he has met this criterion. There is no documentation submitted for review that states the claimant has undergone an injection with temporary relief. Therefore, the claimant does not meet ODG guidelines and the request for outpatient examination under anesthesia, arthroscopy with debridement, subacromial decompression, Mumford and rotator cuff repair for the right shoulder is not medically necessary.

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</p>
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	<p>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</p> <p>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.</p> <p>(Washington, 2002)</p> <p>For average hospital LOS if criteria are met, see Hospital length of stay (LOS).</p>
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<p>Surgery for impingement syndrome</p>	<p><u>ODG Indications for Surgery™ -- Acromioplasty:</u></p> <p>Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.)</p> <p>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</p> <p>2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS</p> <p>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</p> <p>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.</p> <p>(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)**