

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: July 23, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Shoulder Arthroscopy, SAD w/ partial Acromioplasty, Coracoacromial Release ((1) 29826 decompression of subacromial space with partial acromioplasty with coracoacromial release and (2) 29827 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:

11-07-12: Office Visit Transcription

11-07-12: Texas Workers' Compensation Work Status Report

11-09-12: Therapy Transcription at Medical Center

11-11-12: Texas Workers' Compensation Work Status Report

11-19-12: Outcome of Review of Requested Treatment from Workers' Comp Services

11-20-12: Therapy Transcription

11-26-12: Therapy Transcription

11-28-12: Worker's Compensation Explanation of Benefits

11-29-12: Therapy Transcription

12-03-12: Therapy Transcription

12-06-12: Therapy Transcription

12-10-12: Therapy Transcription
12-20-12: Progress Note
12-22-12: Texas Workers' Compensation Work Status Report
12-27-12: MRI Shoulder without Contrast – Right
01-03-13: Texas Workers' Compensation Work Status Report
01-23-13: Worker's Compensation Explanation of Benefits
02-04-13: Progress Note
02-04-13: Texas Workers' Compensation Work Status Report
02-07-13: Texas Workers' Compensation Work Status Report
02-18-13: Request for Reconsideration/Status Check
02-18-13: Texas Workers' Compensation Work Status Report
05-13-13: Progress Note
05-19-13: Texas Workers' Compensation Work Status Report
05-30-13: Office or Other Outpatient Services Office Visit
05-30-13: Texas Workers' Compensation Work Status Report
06-06-13: Office or Other Outpatient Services Office Visit
06-06-13: Texas Workers' Compensation Work Status Report
06-07-13: Claims Submitted for Payment
06-10-13: Pre-Authorization Request
06-11-13: Claims Submitted for Payment
06-11-13: Pre-Authorization Request
06-14-13: MRI Shoulder w/o Contrast
06-14-13: UR performed
06-19-13: Appeal Request
06-27-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx while stretching across his body to insert product into mold repetitively above his head, injuring his right shoulder. He stated that he felt a pop and the next day awoke with severe pain over the lateral aspect of the right upper arm and shoulder.

11-07-12: Office Visit Transcription. Claimant reported left shoulder pain 2-3/10 now, but 9/10 pain at the end of a work day. He reported also tingling of entire left hand tingling of entire left hand in the AM that quickly resolves on its own. He gets some relief with an old RX of hydrocodone. He is also taking ibuprofen 800mg occasionally. He states that pain is sharp and located over the lateral portion of the shoulder. History of Left shoulder surgery 2011. He is left hand dominant. PE: Musculoskeletal: Left shoulder: tenderness of the lateral and anterior portion of the shoulder. Reported pain is disproportionate to stimuli. Full abduction but with pain. Forward flexion to 70 degrees, full internal and external rotation. Unable to test impingement, positive sulcus sign. Assessment: Shoulder pain 7/10, possible impingement. Plan: The claimant has a musculoskeletal injury for which a structured physical therapy program is medically necessary due to limited ROM and clinically relevant pain. The condition limits his ability to perform the essential functions of the job. Management will include modalities, massage, stretching/strengthening, in conjunction with therapeutic exercises. The plan is to focus on functional

outcomes and return to regular work. The program is anticipated to require 4-10 visits or less, depending on recovery and functional outcomes. He may require additional visits, but only if objective improvements can be demonstrated. Claimant instructed to take OTC ibuprofen 200-400mg every 6 hours for pain; needs limit lifting to approximately 14 pounds; no lifting above chest level with affected arm; recheck in 1 week.

11-09-12: Therapy Transcription. Claimant referred for therapy with medical diagnosis of Right Shoulder strain. Chief complaint: pain in shoulder especially at night that is exacerbated by certain movements and alleviated by just not moving. Objective: AROM WNL, Manual muscle testing in Neutral Left, Right: Flexion: 3+/5, 5/5; Extension: 3+/5, 5/5; External Rotation: 4-/5, 5/5; Internal Rotation: 4-/5, 5/5; Abduction: 3-/5, 5/5; Adduction: 4/5, 5/5. Instability of Glenohumeral Joint. Impingement: right painful arc sign. Assessment: The examination is consistent with the medical diagnosis of right shoulder strain. The impingement identified during the examination prevents the claimant from performing their standard activities of daily living and work activities and are addressed in the Goals section. Impairment List: AROM, PROM, Pain. Plan: Frequency: 2 to 3 per week for Duration: 2 to 3 weeks; HEP; Electrical stimulation unattended PRN.

11-19-12: Outcome of Review of Requested Treatment from Workers' Comp Services. Occupational Therapy 2xWk x 3Wks, Right Shoulder has been determined to be medically necessary.

11-20-12: Therapy Transcription. Subjective: Patient reported doing okay with some pain in the right shoulder. He currently is working with modified activity and tolerated prior treatment without adverse reactions. Objective: Pain: 4/10. AROM: still very weak 3/5 to 3+/5. Assessment: Claimant very pain focused but working at getting better. Plan: continue therapy per treatment plan.

11-29-12: Therapy Transcription. Claimant reported he is still having pain in his shoulder but points more to the lateral arm. Noted the claimant is slow in progress of improvement. Plan: continue treatment plan.

12-20-12: Progress Note. Claimant complained of right shoulder pain 6-7/10 and reported no improvement. He does not feel that physical therapy has helped. PE: Musculoskeletal: Abduction limited to 90 degrees otherwise PROM but lateral shoulder pain with all movement, tenderness to deltoid, pain with RTC testing. Assessment: Shoulder pain 7/10, possible RTC tear. Plan: will hold off on PT, MRI ordered, continued restrictions; recheck after MRI or 2 weeks.

12-27-12: MRI Shoulder without Contrast – Right. Impression: 1. Subacromial and subdeltoid bursitis. 2. Tiny signal change within the posterior fibers of distal supraspinatus tendon could be a minimal intrasubstance partial tear or tendinosis.

02-04-13: Progress Note. Claimant complained of right shoulder pain 4/10 and tingling now and every AM. Right arm weakness is present with increased neck pain since injury. PE: Musculoskeletal: Cervical: some tenderness to upper

trapezius. Right shoulder: pain to the deltoid with impingement testing. Positive O'Brien. Assessment: 1. Supraspinatus strain 840.6. 2. Right hand paresthesias. Plan: wrist brace for right; ortho referral for shoulder; continue restrictions; RTC 10 days.

05-13-13: Progress Note. Claimant still feeling pain and cannot lift arm up above shoulders without assistance. Pain is affecting his sleep with pain 6/10. PE: Musculoskeletal: Right Shoulder: Claimant is in mild distress. TTP superior anterior shoulder. Abduction is about 80 degrees, fwd flexion to about 130 degrees, internal rotation to about T12. Sensation to fingers preserved. Strength $\frac{3}{4}$ to all planes except external rotation 4+/5 and the claimant is unable to hold the position for impingement testing due to pain. DTR 2+ bilateral. Assessment: Rotator cuff strain 840.4. Plan: re-refer to ortho; continued restrictions; RTC 10 days.

05-30-13: Office or Other Outpatient Services Office Visit. Assessment: Current problems: 719.41 Pain in joint shoulder, right. Plan: Activity modification, activities as tolerated. Avoid painful activities as much as possible. Continue HEP and initiate ice treatment. Follow-up in one week. If no improvement will order MRI. HPI: Current pain 6/10 and having difficulty sleeping. He is currently taking ibuprofen and Norco. HE has tried ice and heat and has had no prior injury or surgery to the right shoulder. PE: Musculoskeletal: Right shoulder girdle and arm: tenderness present right shoulder mild to moderate, present subacromial region – mild. Glenohumeral joint mild. Positive impingement sign. Injection given to the right subacromial space of dexamethasone sodium phosphate 1mg.

06-06-13: Office or Other Outpatient Services Office Visit. Assessment: Current problem: 719.41 Pain in joint shoulder, right; Partial rotator cuff tear, 726.2 Shoulder, impingement, right. Plan: activity modification, activity as tolerated, return to work with modified duty. Schedule follow-up after scheduled surgery. Recommend arthroscopy of the shoulder. Chief complaint: right shoulder pain. Claimant noted pain relief after injection for 5 days. PE: Musculoskeletal: Right shoulder girdle and arm: tenderness present right shoulder mild to moderate, present subacromial region – mild. Glenohumeral joint. Mild decrease ROM with pain. Positive impingement sign. Tests and procedures to be scheduled: 73221 MRI shoulder w/o contrast.

06-14-13: MRI Shoulder w/o Contrast. Impression: 1. Unstable os acromiale. 2. Minimal acromioclavicular joint osteoarthritis. 3. Supraspinatus and subscapularis tendinopathy. No rotator cuff tear. 4. Severe subacromial-subdeltoid bursitis. 5. Possible superior labral tear.

06-14-13: UR performed. Reason for denial: The clinical information submitted for review fails to meet the evidence based guidelines for requested service. The mechanism of injury was noted as strain to the right shoulder. Medication regimen was not specifically stated. Surgical history was not specifically stated. Diagnostic studies include MRI of the right shoulder dated 12/27/12 which revealed: (1) Subacromial and subdeltoid bursitis; (2) Tiny signal change within

the posterior fibers of distal supraspinatus tendon could be a minimal intrasubstance partial tear or tendinosis. Other therapies include physical therapy, frequency and duration not stated injection therapy, frequency and duration not stated. The request for 1) 29826 Decompression of subacromial space with partial acromioplasty with coracoacromial release 2) 29827 rotator cuff repair is non-certified. The clinical documentation submitted for review evidences the claimant continues to present with right shoulder pain complaints status post a injury in xx/xxxx. There was 1 physical therapy note submitted for review evidencing the claimant attended 1 sessions, it is unclear the duration or frequency of supervised therapeutic interventions. The clinical notes did not evidence that the claimant presented with any objective functional deficits of range of motion to the right shoulder to support surgical interventions at this point in his treatment. The clinical notes document his motor strength is intact as anterior tenderness reported to the shoulder mild to moderate and at the subacromial region. The imaging study of the claimant's right shoulder evidenced a tiny intrasubstance signal change within the posterior fibers of the distal supraspinatus tendon. Given the lack of significant objective findings of symptomatology, the request for decompression of the subacromial space with partial acromioplasty coracoacromial release and rotator cuff repair are not indicated. As such, given all the above, the request for 1) 29826 Decompression of subacromial space with partial acromioplasty with coracoacromial release 2) 29827 rotator cuff repair is non-certified.

06-27-13: UR performed. Reason for denial: The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The claimant's mechanism of injury was noted to be stretching his body to insert product into mold repetitively. The claimant's medications were not provided in the medical records. The claimant's surgical history was not provided in the medical records. Diagnostic studies are noted to include an official MRI of the right shoulder without contrast report dated 12/27/2012, as read, suggested subacromial and subdeltoid bursitis, tiny signal change was noted within the posterior fibers of distal supraspinatus tendon which was noted to be possibly a minimal intrasubstance partial tear or tendinosis. Other therapies are noted to include physical therapy and injections. The request for (1) 29826 decompression of subacromial space with partial acromioplasty with coracoacromial release and (2) 29827 rotator cuff repair is non-certified. The request was previously denied due to lack of significant objective findings of symptomatology were not identified. The claimant is a male who reported an injury on xx/xx/xx. The guidelines recommend 3 to 6 months of conservative care directed toward regaining full range of motion, subjective findings to include pain with active arc of motion and pain at night, objective findings include weak or absent abduction, positive impingement sign, and temporary relief of pain with anesthetic injection, and imaging findings to include positive evidence of deficit in rotator cuff. The documentation submitted for review indicated the claimant to have mild to moderate pain in the anterior shoulder and mild pain in the subacromial region. Range of motion was noted to be mildly decreased with pain and impingement sign was noted to be positive. The documentation submitted for review indicated failed conservative care, to include physical therapy and injections. However,

documentation submitted for review did not indicate the duration of the attended physical therapy or an objective patient response to the injections performed. Based on the documentation submitted for review failed conservative care for 3 to 6 months, objective findings of painful range of motion between 90 degrees and 130 degrees are not identified. As such, the request for (1) 29826 decompression of subacromial space with partial acromioplasty with coracoacromial release and (2) 29827 rotator cuff repair is non-certified.

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

The previous adverse decisions are agreed upon and upheld. The MRI findings and X-rays presented in the documentation present no evidence of a rotator cuff tear or of impingement. There is no surgically correctable lesion that has been diagnosed thus far. It is most likely that the claimant has chronic tendinitis and bursitis, neither which would improve with a surgical procedure. Therefore after review of the medical records and documentation provided, the request for Shoulder Arthroscopy, SAD w/ partial Acromioplasty, Coracoacromial Release ((1) 29826 decompression of subacromial space with partial acromioplasty with coracoacromial release and (2) 29827 rotator cuff repair) is not medically necessary and therefore denied.

Per ODG:

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>
Surgery for rotator cuff repair	<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.)</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 (Tenderness over the greater tuberosity is common in acute cases.) 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 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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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)**