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Notice of Independent Review Decision

DATE: June 6, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Arthroscopy, Shoulder, Surgical; with Lysis and Resection of Adhesions, with or without Manipulation

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 Orthopaedic 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:
10/03/12: Right Shoulder Arthrogram report
10/03/12: MR Shoulder with Contrast report
11/05/12: Physical Therapy Discharge Notes
11/13/12: UR performed
11/27/12, 12/10/12: Progress Note
01/29/13: Notification of Appointment
02/01/13: Designated Doctor Evaluation
04/08/13: General Orthopaedic Clinic Note
04/16/13: Preauthorization Request
04/17/13: UR performed
04/24/13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who injured his right shoulder when he was moving while at work on xx/xx/xx.

10/03/12: MR Shoulder with Contrast (Right) report interpreted. CONCLUSION: Essentially normal MRI of the right shoulder. No rotator cuff tear or labral injury. Indistinctness is seen in the superior glenohumeral ligament which is felt to be iatrogenic as this is the site of needle placement.

11/05/12: Physical Therapy Discharge Notes from Health System. Diagnosis: Right shoulder pain/subacromial bursitis; failed conservative treatment and injection. It was noted that the claimant had been seen by PT four times since 10/30/12. His current complaints were 3/10 right shoulder pain. On exam, he had anterior right shoulder tenderness and pain with ROM. Muscle strength was 4+/5.

11/13/12: UR performed for request for additional physical therapy noted that the claimant had completed 15 PT visits to date. It was documented that had given the claimant an SA injection which helped. The request for additional PT was denied.

11/27/12: The claimant was evaluated for right shoulder pain. He stated that was sore and was taking medication as needed. It was noted that he “no longer has any significant pain and feels that his function is near normal.” On physical exam DTRs were normal. Sensation was intact. Motor strength was 5/5. There was full ROM of the right shoulder without crepitus or pain. Negative impingement sign. There was no tenderness or pain to palpation throughout the shoulder region. He was instructed to continue with the home exercises program. He could return to regular activity without restrictions.

12/10/12: The claimant was evaluated for followup of the right shoulder. He stated that the pattern of symptoms was worsening. He had been taking medications and noted some relief of his symptoms. It was noted that his symptoms worsened after working on a heating/cooling unit overhead. His pain was rated 6/10 and exacerbated by raising arms overhead, lifting, or carrying. The symptoms were alleviated by resting. On physical exam, DTRs were normal. Sensation was intact. Motor testing was 5/5 of major flexors/extensors. Gross exam of the shoulder revealed no abnormalities on appearance. Normal shoulder ROM noted in all planes with pain. Testing revealed equivocal signs of impingement. Strength testing of supraspinatus demonstrated weakness to resistance. Pain to resisted flexion was noted. Palpation of the shoulder demonstrated moderate tenderness anteriorly. He was instructed to limit lifting, pushing, and pulling to approximately 30 pounds and limit overhead work.

02/01/13: The claimant as evaluated. He complained of persistent pain, particularly when trying to bring his arm up from the side and holding his arm above his head. On physical exam, he was noted to have difficulty removing his shirt and getting his shirt over his right arm. There was no obvious atrophy of the visible periscapuar musculature. There was no significant tenderness over the acromioclavicular joint. Some subacromial tenderness was noted. Range of motion was significantly limited in abduction, internal rotation, and forward flexion.

Mildly positive impingement sign was noted on forward flexion. Mild weakness was noted in resisted internal and external rotation as well as abduction. Negative Tinel at the right elbow or wrist. Negative Phalen and reverse Phalen. No weakness in the intrinsic musculature of the hand. No thenar or hypothenar atrophy. IMPRESSION: Sprain/strain, right shoulder. Adhesive capsulitis. He expected to reach MMI by August 1, 2013.

04/08/13: The claimant was evaluated for right shoulder pain. He complained of pain with his arm away from his body. He denied any paresthesias. He denied any radiation of shoulder symptoms. On physical exam, he had fairly good range of motion with discomfort at extremes in the right shoulder. AATE 175 degrees with discomfort past 125 degrees. Negative Neer and positive Hawkins impingement sign. Tender over the AC joint. Pain and weakness and both Speed and drop-arm test. Internal rotation to the sacrum and external rotation to the occiput. X-rays of the right shoulder demonstrated no acute bony abnormalities. MRI report did not reveal tears involving the right shoulder. It was noted that he had undergone 24 sessions of PT, which gave him more motion, but he was still symptomatic. He was considering a surgical procedure. He was to continue rehab exercise to help recover afterwards. He was returned to work at light duty. A request was made for right shoulder EUA, DX arthroscopy with debridement, SAD, Mumford for shoulder impingement syndrome, traumatic arthropathy.

04/17/13: UR performed. Explanation of Findings: Guideline criteria have not been met. The patient is noted with complaints of pain in the right shoulder, despite medication and pt. There is documentation noting discomfort at extremes of motion, positive impingement signs, tenderness over the AC joint, and pain and weakness with Speed and drop-arm test. However, MRI is noted to be essentially normal with no rotator cuff tear or labral injury. X-rays reveal no bony abnormalities. Furthermore, there is no documentation noting a trial/failure of anesthetic injection (diagnostic injection test) and/or trial of a cortisone injection. Therefore, this request is not indicated as medically necessary at this time.

04/24/13: UR performed. Explanation of Findings: There is no indication that a subacromial injection has been attempted yet. There is no cuff tear on MRI. The evidence based guidelines recommend attempting injection to reduce symptoms and to try to avoid surgery. The patient has impingement with failure of PT, medication, activity modification. It is unclear why an injection performed, as this is part of the standard of care treatment protocol prior to surgical intervention. Therefore, the right shoulder examination under anesthesia, diagnostic arthroscopy with subacromial decompression and Mumford are not medically necessary per evidence based guidelines.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse decisions are upheld. The claimant was injured on xx/xx/xx. There were no findings to suggest a need for surgery. In November of 2012, he was released to full activity. His MRI did not show an acute injury that would require surgery or that he would benefit from surgery. There is no evidence of rotator cuff tear. ODG state that there must be evidence of impingement on imaging studies. The claimant does not meet ODG criteria. Therefore, the request for Arthroscopy, Shoulder, Surgical; With Lysis and Resection of Adhesions, with or without Manipulation is not medically necessary is not certified.

ODG:

Diagnostic arthroscopy	Recommended as indicated below. **Criteria** for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear. (Washington, 2002) (de Jager, 2004) (Kaplan, 2004) For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

Surgery for impingement syndrome	**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)

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)**