CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: September 19, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right Shoulder Arthroscopy with Rotator Cuff Repair, Debridement, and Subacromial Decompression

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a 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:
12/07/10: Evaluation
12/10/10: Evaluation
12/27/10: Evaluation
01/11/11: Physical Therapy Re-evaluation
01/14/11: Evaluation
06/04/11: MRI of the Right Shoulder without Contrast
06/04/11: MRI of the Left Shoulder without Contrast
02/06/12: Lumbar Spine MRI
11/01/12: Operative Note: Lumbar Epidural Steroid Injection
11/09/12: Orthopedic Consult
12/17/12: Orthopedic Report
01/29/13: Orthopedic Report
03/11/13: Orthopedic Report

04/23/13: Orthopedic Report
05/23/13: Orthopedic Report
06/25/13: Orthopedic Report
07/09/13: UR completed
07/25/13: Orthopedic Report
08/27/13: UR completed
Physical Therapy Progress Notes: 12/16/10, 12/17/10, 12/20/10, 12/21//10, 12/22/10, 12/27/10, 12/30/10, 01/03/11, 01/04/11, 01/11/11

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who sustained injuries to her cervical spine, lumbar spine, and bilateral shoulders on xx/xx/xx. It was reported she was performing her usual job duties. She initially went under the care and had physical therapy. She was then referred and underwent a lumbar ESI. In November 2012 she came under the Orthopedic care. Past medical history is note to be positive for bilateral shoulder injury in xxxx.

On June 4, 2011, MRI of the Right Shoulder, Impression: 1. Full thickness tear of the supraspinatus tendon with a 2.1 cm gap or separation as measured transversely on the coronal images. 2. Bursitis-synovitis in the subcoracoid-supscapularis bursa and subacromial subdeltoid bursa. 3. Biceps tendon tenosynovitis.

On November 9, 2012, the claimant was evaluated for low back pain 5/10, neck pain 5/10, right shoulder pain 6/10 and left shoulder pain 5/10. The right shoulder pain was described as discomfort with above-head reaching, soreness, stiffness, and nighttime pain. Physical examination was confined to the lumbar spine. Impression: 1. Disk protrusion, L5-S1 with foraminal stenosis and neurogenic claudication. 2. Cervical strain, possible HNP. 3. Contusion and aggravation of her bilateral shoulder symptoms. Plan: Possible cervical MRI and additional physical therapy for her shoulders.

On December 17, 2012, the claimant was re-evaluated. It was noted during the physical exam of her cervical spine that there was tenderness on her right and left posterior cervical region with moderate range of motion in all directions and positive axial compression test. Her upper extremity motor strength and sensation were decreased bilaterally and her reflexes were blunted in her biceps, tricpes, and brachioradialis. Plan: With regard to the bilateral shoulders, corticosteroid injections.

On March 11, 2013, the claimant was re-evaluated for right shoulder pain 5/10. Medications included Ibuprofen 800 mg, Lorcet 10-650, Soma 350 mg, and Ambien 10 mg. Plan: Cervical ESI in conjunction with post injection therapy. Right shoulder arthroscopy with RTC repair.

On May 23, 2013, the claimant was re-evaluated for right shoulder pain 6/10. Procedure Note: The subacromial bursa was injected with 1% lidocaine, .25% marcaine and 40 mg kenalog.

On June 25, 2013, the claimant was re-evaluated who reported the claimant continued to remain symptomatic in the right shoulder even though she had been through PT, oral NSAIDS, injections and activity modification. MRI revealed full thickness tear, consistent with physical exam findings, and therefore would proceed with right shoulder arthroscopy. (Note: no physical exam was documented regarding the right shoulder).

On July 9, 2013, completed a UR. Rationale for Denial: Although the claimant reportedly has had conservative treatment failure such as oral medications, physical therapy, injection, and activity modification, recent objective physical examination findings have not been provided and evaluation for cervical pathology has not been noted. The claimant has had reports of cervical pain and cervical injury without diagnostic imaging ruling out cervical pathology. Additionally, a recent objective physical examination findings documenting weakness with abduction testing, muscular atrophy, or deficits in range of motion or strength have not been noted in the records reviewed.

On August 27, 2013, completed a UR. Rationale for Denial: The previous non-certification on July 8, 2013 was due to lack of full evaluation for cervical spinal pathology. The previous non-certification is supported. Additional records included a reconsideration letter from July 25, 2013, which noted the claimant has had prior recommendations for a cervical MRI which were non-certified by the insurance provider. The claimant was noted to be currently undergoing a work up for cervical pathology although has clear evidence of right shoulder rotator cuff full-thickness tear and requires surgical intervention. The claimant has persistent reports of cervical pain and cervical injury without diagnostic imaging to rule out cervical pathology. There are subjective reports of radicular symptoms on physical examination. Recent objective physical examination findings noting weakness with abduction testing, muscular atrophy, or deficits in range of motion have not been documented. The guidelines would not support surgical intervention without full evaluation for cervical pathology. The criteria for a rotator cuff repair should include a diagnosis of a full-thickness rotator cuff tear and cervical pathology should be ruled out. The request for reconsideration of a right shoulder arthroscopy with rotator cuff repair, debridement, and subacromial decompression is not certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse determinations are upheld. There is a lack of physical exam findings for the right shoulder to confirm rotator cuff signs in the documentation provided for my review. The cervical pathology has also not been ruled out as the cause of weakness. Therefore, the request for Right Shoulder Arthroscopy with Rotator Cuff Repair, Debridement, and Subacromial Decompression does not meet ODG criteria and is found to not be medically necessary at this time.

PER ODG:

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)

ODG Indications for Surgery™ -- Rotator cuff repair:
Criteria for rotator cuff repair with diagnosis of full thickness 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 partial thickness 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).

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)**