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Notice of Independent Review Decision

October 23, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder Reconstruction: RTC Repair, Labral Repair, AC Joint Resection, Distal Clavicle Resection, Debridement to Include CPT Code 23420, 29823, 23120, 29807

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

The Reviewer is a Board Certified Orthopaedic Surgeon with over 13 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male, who was injured on xx/xx/xx. The claimant was diagnosed with acromioclavicular joint separation, a type III acromion, a labral tear, and glenoid labral tear.

05/02/2014: Evaluation. **HPI:** Claimant reported shoulder pain, stiffness and decreased ROM. The claimant describes symptoms as moderate in severity and worsening. Symptoms are exacerbated by motion at the shoulder. **PE:** Shoulder: Left: No pain and full ROM. Right: ROM Decreased. Movements painful, adduction restricted. Internal rotation restricted. **Plan:** Referred to PT.

05/09/2014: Evaluation. Claimant reported Rt shoulder has gotten worse since last visit. Claimant describes pain in Rt shoulder as shooting, rating pain as a 10. Sudden movement worsens pain. **Plan:** Started taking Tramadol HCl50mg. Referred to MRI.

05/22/2014: MRI Right Shoulder. **Impression:** Glenohumeral osteoarthritis with diffuse degenerative labral tearing and prominent subchondral cysts along the inferior glenoid. Rotator cuff tendinosis with chronic interstitial low-grade partial tearing of the subscapularis. Tendinosis and fraying of the long head bicep. Acromioclavicular osteoarthritis with type 3 acromion. Diffuse degenerative labral tear. Low-grade undersurface fraying distal supraspinatus and infraspinatus with background tendinosis.

06/12/2014: Evaluation. **PE:** Claimant cannot elevate his arm in the forward planes. He cannot turn his arm down even in the thumb down position against resistance at all causing dramatic pain and discomfort over the anterolateral acromion and AC joint. The patient has exquisite tenderness to palpation over the AC joint with a palpable fullness over the AC joint present in this right shoulder. He also has anterior and posterior joint pain with internal and external rotation motions and significant limitations in ROM even on passive PE. **Current Medications:** Metformin, tramadol, some blood pressure medicine and cholesterol medicine.

06/20/2014: PT Evaluation. Claimant reports pain a 7. ADL's: 30%. **Assessment:** Claimant present with severe right shoulder pain and weakness secondary to RTC causing significant deficits upper extremity function and ability to perform ADL's. He would benefit from skilled PT for pain management, ROM, scapular stabilization, UR strengthening and home program instruction. Prognosis fair secondary to RCT. The claimant rehab potential is fair. The claimant's discharge prognosis is fair. **ROM:** Right Shoulder: External Rotation Prom-20. Internal Rotation Prom- 30. Scaption PROM- 80. Flexion AROM- 125.

07/25/2014: PT Discharge Summary. Claimant reported pain at a 5. Claimant reports right shoulder pain. Claimant has attended a total of 13 treatment sessions. **ADL's:** 30%. **Assessment:** The patient is able to perform exercises with difficulty due to pain. The patient's progress towards goals is poor and his tolerance to treatment is fair. Patient consents to treatment plan and goals and gives verbal informed consent. Client has had fair response to skilled intervention with mild decreased in pain levels. Client has fair to good tolerance to light scapular and shoulder stabilization exercise with proximal humerus stabilization and has been instructed in HEP for continued stabilization and ROM maintenance. Unable to tolerate supine positioning for long periods or palpation. Client will be d/c at this and is following up with orthopedic surgeon. **Evaluation:** Patient present with severe right shoulder pain and weakness secondary to RCT causing significant deficits upper extremity function and ability to perform usual ADL's. He would benefit from skilled PT for pain management, ROM, scapular stabilization, UE strengthening and home program instruction. Prognosis fair secondary to RCT.

07/29/2014: Evaluation. **PE:** Claimant has been in PT with no significant results. The claimant does have significant underneath surface fraying and tear of the supraspinatus tendon with significant intertendinous changes of the supraspinatus tendon we have called a tear. He has type III AC joint with a subluxed AC joint subluxation tear indicating a significant capsulitis and tearing of the AC joint cartilage. He has a significant tear of the diffuse tear of the anterior labral cartilage of the patient's right shoulder. The patient is far enough out now where he cannot really raise his arm past neutral, he cannot lift, push or pull and cannot reach in the back seat and cannot roll over on his shoulder at night. The patient is losing range of motion, not gaining range of motion. He has been in therapy now for a month. He had 12 sessions of PT and have not seen any significant response. The patient is neurovascular intact. There are no dermatologic or lymphatic changes otherwise. The patient understands what is wrong with his shoulder and would like to have it fixed to where he could go back to work. The patient cannot perform the activities of his job at this time. The patient has failed pt with the pain continuing to get worse with the patient's functional level continuing to drop and without the ability to lift, push or pull with his right upper extremity. My recommendation would be rotator cuff repair, AC joint reconstruction with distal clavicle resection, subacromial decompression and repair of the rotator cuff and the labral cartilage. **Plan:** Will work on getting the patient set up and taken care of where we could get him back to work in a reasonable amount of time after operative intervention.

09/03/2014: UR. Rational for Denial: The claimant is a male, who was injured on xx/xx/xx. The claimant was diagnosed with acromioclavicular joint separation, a type III acromion, a labral tear, and a glenoid labral tear. The claimants date of injury was in xxxx with no indication of lower levels of care have been intermittent or continuous. The records do not reflect evidence of impingement on physical examination or temporary relief with a corticosteroid injection. The claimant is diabetic and steroid injections are withheld due to the risk of increased blood sugar. The MRI reported fraying but no evidence of a partial or full-thickness tear. The records do not reflect type II or IV labral lesion. The finding on the MRI are degenerative in nature. The request for a right shoulder reconstruction, rotator cuff repair, labral repair, acromioclavicular joint resection, distal clavicle resection, and debridement is not certified.

09/19/2014: UR. Rationale for Denial: The claimant is a male who was injured on xx/xx/xx. The claimant was diagnosed with acromioclavicular joint separation, Type III acromion, and a glenoid labral tear. The provided imaging demonstrated degenerative changes in the shoulder. There is no documentation that the claimant has a positive impingement sign with temporary relief with an anesthetic injection. There was no indication on imaging if there was a Type II or Type IV labral tear, as required by the guidelines. The request for right shoulder reconstruction, rotator cuff repair, labral repair, acromioclavicular joint resection, distal clavicle resection, and debridement with bone marrow aspirate and platelet-rich plasma is not certified.

09/19/2014: Impairment Rating. **Orthopedic Shoulder Evaluation: (1)**
Decreased ROM: Flexion 60 degrees 8 ueir. Extension 0 degrees 3 ueir.
Adduction 10 degrees 1 ueir. Abduction 40 degrees 6 ueir. Int Rot 30 degrees 4
ueir. Ext Rot 30 degrees 1 ueir. **(2)**TTP. **(3)** – Drop Arm. **(4)** + Apprehension.
(5) + Apley’s Scratch. **(6)** Flexion 4/5, Abduction 4/5, Adduction 4/5, Int Rot 4/5,
Ext Rot 4/5. **(7)** No surgical scar. **(8)** - Impingement sign.

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

The patient is not indicated for right shoulder reconstruction with rotator cuff repair, labral repair, distal clavicle resection and debridement.

The patient’s May 2014 MRI demonstrated rotator cuff tendonitis and glenohumeral osteoarthritis. There is no evidence of a full thickness or high-grade partial thickness rotator cuff tear that requires repair. In addition, there is no documentation of an impingement sign, which would point toward the rotator cuff pathology as a source of pain.

The patient also has moderate glenohumeral osteoarthritis, associated with subchondral cysts and a medial osteophyte of the inferior humeral head. This degree of osteoarthritis will remain a source of pain and limited motion despite any arthroscopic debridement procedure or repair. This patient will eventually require a shoulder replacement.

Arthroscopic surgery is not medically necessary for this patient.

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)**