

# Medical Assessments, Inc.

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## Notice of Independent Review Decision

January 20, 2014

### **IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

OP Right Shoulder Scope/AC Joint Resection/Subacromial Decompression/RTC Repair

### **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 42 years of experience.

### **REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

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:**

08/23/2013: Out Patient Encounter Record  
09/13/2013: MRI of Right Shoulder  
10/31/2013: Evaluation  
11/06/2013: UR performed  
12/30/2013: UR performed

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who reported an injury on xx/xx/xx as a result of a trip and fall onto the shoulder.

08/23/2013: Out Patient Encounter Record. **HPI:** Right shoulder symptoms better, has pain with ROM. Shoulder movement was painful, especially with

abduction and external rotation. **Assessment:** Right biceps strain. Right Shoulder pain. **Plan:** MRI right shoulder.

09/13/2013: MRI of Right Shoulder. **Impressions:** 1. Right shoulder severe hypertrophic degenerative changes in the acromioclavicular joint producing moderate impingement upon the underlying rotator cuff supraspinatus myotendinous junction. 2. Supraspinatus tendon critical zone irregularity and large amount of abnormal heterogeneous increased signal consistent with multiple partial tears. 3. Glenoid Labrum superior central segment severe degenerative changes and anterior central segment small smooth linear nondisplaced tear. 4. Small effusions in the subdeltoid-subacromial bursa and in the glenohumeral joint. 5. Abnormal appearance of the long head of the biceps tendon, which appears to have partial tear-fraying of the segments visible within the humeral bicipital groove.

10/31/2013: Evaluation. **Past Surgical History:** Positive for previous left shoulder surgery which has questionable results and outcome. **Current Medications:** Metformin, atorvasin, Mctoprolol, fish oil, calcium, aspirin, and multivitamins. **Physical Examination:** The claimant is left with a severe right shoulder injury where he had two of the four tendons of this rotator cuff significantly injured with near full thickness tears and early retraction noted of the supraspinatus and subscapularis tendons. The claimant also has a critical zone tear within the anterior central segment of the glenoid labrum with a large nondisplaced linear tear through the middle and superior aspect of the glenoid labral cartilage with severe injury to the biceps tendon with partial thickness tearing and what looks like a subluxed biceps tendon out of the bicipital groove with partial thickness tearing and fraying from this injury where the biceps tendon was literally subluxed out of the groove at that time. The claimant has also injured his AC joint. There are significant osseous and capsular soft tissue hypertrophic changes and edema. He does have moderate impingement in his shoulder from a subacromial spur with excrescence and an AC joint. The problem is that the claimant also appears to have a partial separation at the AC joint with bony edema present and exquisite tenderness over the AC joint with pushing down in the posterior, anterior, and inferior aspects of the joint. The claimant has telltale signs of rotator cuff injury with pain in the thumb down position against resistance and really the inability to even rotate the thumb in the down position against resistance at the 45-degrees of internal and external rotation and abduction. He has positive Neer and Hawkins sign of the right shoulder, exquisite capsular tenderness anteriorly with stressing in the glenoid labrum with the biceps with positive Yerganson's sign even for the biceps tendon injury. The plain films taken today, 30-degree caudal and 30-degree cephalad show significant AC joint spurring, and subacromial articular changes. No significant glenohumeral arthritic changes are noted and not evidence of any type of calcific tendinitis. **Plan:** Will work on getting the claimant set up for operative intervention reconstruction of the right shoulder of rotator cuff tear, subacromial decompression, AC joint resection, a labral cartilage repair with trying also from the subscapular injury he suffered with the subluxation at the same time and work on trying to help present a full thickness biceps tendon tear, which is where he is headed right now.

11/06/2013: UR performed. Rational for Denial: While the documentation submitted for review indicates that the patient has significant findings on examination as well as MRI, the Official Disability Guidelines indicate in the criteria for surgery that there is a necessity for the patient to have completed and exhausted conservative care for a period of 3 to 6 months. Given the lack of documentation of conservative care having been undertaken for the patient prior to the request for surgery, surgical intervention is not supported. Given the above, the request for OP right shoulder scope/AC joint resection/subacromial decompression/RTC repair 23130, 23120, 29826, 23420, is non-certified.

12/30/2013: UR performed. Rational for Denial: This request was previously reviewed and received an adverse determination due to lack of documentation of conservative care. There was no new clinical documentation submitted for review. Official Disability Guidelines recommend surgical intervention for a rotator cuff repair and impingement syndrome after 3 to 6 months of conservative care has failed to resolve the patient's symptoms. The clinical documentation submitted for review does not indicate that the patient has undergone any conservative care. There is no evidence of physical therapy, or injection therapy.

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

The previous adverse determinations are overturned. After reviewing this record, I have determined that the surgery, Arthroscopic Surgery to left shoulder to repair rotator cuff tear, and debridement of a-c joint is indicated. Conservative care would not likely be helpful pre op. The sooner the surgery can be done the more likely it will be successful. Putting it off for 6 months would only allow more retraction of the cuff tear and make successful repair less likely. Therefore, the request for OP Right Shoulder Scope/AC Joint Resection/Subacromial Decompression/RTC Repair is certified.

## ODG Guidelines:

### **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.

### **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).

### **DG Indications for Surgery™ -- Acromioclavicular dislocation:**

*Not recommended, but if used anyway,* **Criteria** for surgical treatment of acromioclavicular dislocation with diagnosis of acute or chronic shoulder AC joint separation:

- 1. Conservative Care:** Recommend at least 3 months. *Most patients with grade III AC dislocations are best treated non-operatively.* PLUS
- 2. Subjective Clinical Findings:** Pain with marked functional difficulty. PLUS
- 3. Objective Clinical Findings:** Marked deformity. PLUS
- 4. Imaging Clinical Findings:** Conventional x-rays show Grade III+ separation.

**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)**