

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** October 6, 2014

**IRO CASE #:**

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

Left Shoulder Scope, Subacromial Decompression, and Rotator Cuff Repair with Possible Arthroscopy

**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 Surgery with over 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.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who injured his left shoulder on xx/xx/xx.

05/05/14: The claimant was evaluated on his sixth visit. He reported increased pain since the weekend, denied remembering injury/trauma, currently 8/10. Impairment list: AROM, pain, muscle performance, motor function. His overall progress was as expected. He had achieved functional goal of pushing/pulling a 100 lb sled a total of 5 minutes on 04/29/14. He achieved impairment goal of AROM left shoulder flexion 170 degrees on 05/02/14. He achieved grip strength of 105 lb dynamometer on 05/02/14. He achieved muscle performance left shoulder abduction 5/5 on 05/02/14. He was to continue per plan of care, progress as tolerated.

05/28/14: MRI Left Shoulder report. IMPRESSION: Partial thickness foot print tear of the supraspinatus tendon, anteriorly. There is also some associated tendinosis. The rest of the shoulder is negative.

06/05/14: The claimant was evaluated for left shoulder follow up. He stated that his pain was only 1/10 in the posterior aspect of the shoulder, when raising the arm, radiated to neck. He denied numbness or tingling. It was noted that he did PT, which helped slightly with ROM. On exam, he had tenderness of the posterior aspect of the left shoulder and decreased range of motion; abduction 75 degrees with pain. Special tests were not performed. He had a normal left hand grip. He was given a prescription for naproxen 500 mg 1 tab p.o. b.i.d. #60 prn. No therapy was indicated at that time. He was to continue home exercises as prescribed.

06/18/14: The claimant was evaluated for left shoulder pain to the lateral part of his shoulder. He stated that the pain had been present since xx/xx/xx when he sustained a work-related injury. He described the symptoms as sharp. He said that the symptoms were experienced intermittently. His maximum pain level was 8/10. The pain occasionally interfered with ADLs. The symptoms were made worse with reaching up and relieved with arm at side. He admitted to night pain when lying on side. He could lift his arm above head. He did not feel weak. He was able to continue with work/household activities. He had experienced numbness/tingling down the arm that extended to fingers up to the ulnar fingers. He had treated the problem with physical therapy, medications, and being on light duty. The physical therapy lasted for six sessions and resulted in no improvement. Medications included Mobic. It was noted that he had pain and popping with active ROM and felt weak with lifting. On exam, he had good cervical range of motion without pain. Spurling's test was negative, axial compression test negative. The left shoulder was tender laterally over greater tuberosity. No atrophy or winging. Nontender AC joint, nontender SC joint, normal biceps contour. He had pain with ROM, no tightness. No drop arm sign, external rotation 5-/5 strength, abduction 5-/5. No joint instability on provocative testing. AC joint compression test negative. Neer test positive, Hawkins test positive. Reflexes were symmetrical. Sensation was intact. Normal capillary refill, radial artery pulse 2+. ASSESSMENT: Pain shoulder, bursitis/tendonitis shoulder, rotator cuff tear (traumatic). The plan was to order a medical report. He was to avoid heavy lifting, overhead activity, and long arm maneuvers. Shoulder arthroscopy was recommended. He was put on modified duty work status.

06/25/14: A medical record review was performed who concluded that, in medical probability, the claimant sustained an acute tear of the supraspinatus tendon in the anterior fibers based on the mechanism of injury. He noted that further conservative care was indicated, including additional PT, additional work restrictions, and avoidance of cortisone injections. If symptoms were to persist, he noted that surgical care including subacromial decompression and repair of tear would be indicated and done arthroscopically followed by an appropriate amount of PT and adequate treatment with opiate analgesics.

07/03/14: The claimant was evaluated. On exam, he had decreased left shoulder active range of motion; abduction 160 with pain. Special tests were not evaluated. He was given a prescription for naproxen 500 mg 1 p.o. b.i.d. #60.

08/06/14: UR. RATIONALE: ODG does recommend surgery for patients with partial-thickness rotator cuff tears presenting primarily as impingement who fail conservative therapy for three months. The patient was initially treated with PT and medications with no improvement. Subsequent medical records indicate that he continued to have symptoms and complained of pain at night and pain with range of motion. Abduction was to 160 degrees with pain. Neer's and Hawkins' tests were positive. An MRI on 05/28/14 confirmed the partial-thickness footprint tear of the supraspinatus tendon. However, the patient has not received a diagnostic injection test as required per the referenced guidelines prior to the requested surgical procedures. As such, the criteria for the request has not been met, and the request for 1 left shoulder scope, subacromial decompression, and rotator cuff repair with possible Arthroscopy cannot be deemed medically necessary.

08/13/14: The claimant was evaluated. On exam, he had good cervical range of motion without pain. Spurling's test was negative, axial compression test negative. The left shoulder was tender laterally over greater tuberosity. No atrophy or winging. Nontender AC joint, nontender SC joint, normal biceps contour. He had pain with ROM, no tightness. He had give-way weakness on testing. No drop arm sign, external rotation 5-/5 strength, abduction 5-/5. No joint instability on provocative testing. AC joint compression test negative. Neer test positive, Hawkins test positive. Reflexes were symmetrical. Sensation was intact. Normal capillary refill, radial artery pulse 2+. It was noted that the claimant stated the shoulder pain and dysfunction persisted and was made worse by reaching up, lifting, with motion, and at night. He was not happy how his shoulder was responding. He wished to proceed with a diagnostic impingement injection test.

08/21/14: Procedure note. PROCEDURE: Ultrasound guided injection.

09/03/14: The claimant was evaluated. He stated that the injection performed on 08/02/14 only helped his pain for four days. His pain then returned and was rated 6/10. He continued with pain and popping and was not improving. His exam was unchanged. It was recommended to proceed with left shoulder arthroscopy RCR, SAD, and any other indicated procedures.

09/09/14: UR. RATIONALE: The documentation indicates the patient having significant findings involving a rotator cuff repair specifically at the infraspinatus. Therefore, the proposed rotator cuff repair would likely provide some benefit for the patient. However, no information was submitted regarding the need for a subacromial decompression or possible Arthroscopy. Without the significant findings confirmed by imaging studies regarding the need for a possible arthroscopy, this request is not indicated as medically necessary.

**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's history and physical exam do not suggest an impingement syndrome, and his conservative care is not clearly outlined. The Official Disability Guidelines do recommend repair of partial

tears of rotator cuff if conservative care is unsuccessful. However, there are no indications for acromial decompression. As the case does not meet ODG criteria for subacromial decompression or possible arthrotomy, the request for Left Shoulder Scope, Subacromial Decompression, and Rotator Cuff Repair with Possible Arthrotomy is not medically necessary.

ODG:

Surgery for impingement syndrome	<p><b>ODG Indications for Surgery™ -- Acromioplasty:</b>  <b>Criteria</b> for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.)  <b>1. Conservative Care:</b> 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  <b>2. Subjective Clinical Findings:</b> Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS  <b>3. Objective Clinical Findings:</b> 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  <b>4. Imaging Clinical Findings:</b> Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement.  <a href="#">(Washington, 2002)</a></p>
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Surgery for rotator cuff repair	<p><b>ODG Indications for Surgery™ -- Rotator cuff repair:</b>  <b>Criteria</b> 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:  <b>1. Subjective Clinical Findings:</b> Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS  <b>2. Objective Clinical Findings:</b> Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS  <b>3. Imaging Clinical Findings:</b> Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.  <b>Criteria</b> 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.)  <b>1. Conservative Care:</b> 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  <b>2. Subjective Clinical Findings:</b> Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS  <b>3. Objective Clinical Findings:</b> 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  <b>4. Imaging Clinical Findings:</b> Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.  <a href="#">(Washington, 2002)</a>  For average hospital LOS if criteria are met, see <a href="#">Hospital length of stay</a> (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)**