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Notice of Independent Review Decision

January 5, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopy shoulder with coracoacromial ligament release, Rotator Cuff repair of the right shoulder

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 female who was injured on xx/xx/xx. She felt pain in her shoulder.

07/29/2014: Office Visit. **PE:** Musculoskeletal: Normal gait. No tenderness or swelling of extremities. Right shoulder decreased ROM, able to abduct and ant flex to 170 degrees. Pain at 140 degrees, patient weak due to pain compared to left side, shoulder ttp and deltoid and post shoulder. No swelling or deformity. **Plan:** Start Ibuprofen 600mg, start diazepam 2mg, cold hot pack, point relief tube 40 oz. Ordered PT.

08/02/2014: Office Visit. **PE:** Musculoskeletal: Normal gait. Right shoulder decreased ROM. Decreased strength. Provocative maneuver positive for impingement.

08/08/2014: Office Visit. **PE:** Patient says PT is helping. Overall oral meds helping. Patient denies any adverse events with oral meds. Patient complains with home exercise. She is still having pain and rated at moderate but overall more tolerable than before. She feels she has increased ROM compared to last visit. Patient reports due to repetitive type work, she has noticed increasing pain while performing her normal work activities. Work restrictions.

08/18/2014: Office Visit. **HPI:** Patient reported work did not observe work site restrictions and was made to hang clothes and perform repetitive shoulder extensions throwing clothes. Patient reported initially improved but with the new activities pain had worsened. Pain rated as 10/10. At time of visit, pain rated as 7/10 with restricted movement. **PE:** Musculoskeletal: Normal gait. No tenderness, full ROM. **Plan:** Continue OT. Discontinue Ibuprofen. Return to work with restrictions. Modified activity.

08/28/2014: Office Visit. Patient reports constant pain. Reports still taking oral meds and PT. No improvement. Patient reports work restrictions have reduced constant pain to moderate, however, any movement of shoulder still causes severe sharp pain. Patient reports decreased ROM due to pain and says poor quality of life due to pain and limited use of right arm due to pain. **Plan:** Ordered MRI right shoulder. Start Metaxalone 800mg. Continue Ibuprofen 600mg.

08/30/2014: MRI Right Shoulder. **Impression:** 1. Large full thickness tear involving the majority of the distal supraspinatus tendon. There is no supraspinatus muscle atrophy. A small portion of the tendon remains intact far anteriorly and posteriorly, preventing complete rupture and retraction. 2. Intrasubstance and undersurface partial tearing of the distal infraspinatus tendon. 3. Communicating moderate to large glenohumeral joint effusion and subacromial/subdeltoid bursitis fluid collections are present. 4. Sources for rotator cuff impingement in this patient include lateral acromial down sloping and acromioclavicular joint arthrosis.

09/10/2014: Office Visit. Patient reported that she cannot keep up with production and has poor ROM. She is worried about keeping her job. She has severe pain with any movement and oral meds and PT is not helping. **PE:** Decreased ROM and strength right shoulder.

09/24/2014: Office Visit. Reports pain at night 10/10. **PE:** Painful AROM and restricted PROM which was painful. Internal rotation: Painful restricted AROM and restricted PROM which was painful. External rotation: painful restricted AROM and restricted PROM which was painful. Positive painful ARC and positive O'Brien's test, but negative Empty Can test. Negative lift off test. Negative Apprehension test and negative Relocation test. No tenderness and full ROM.

10/08/2014: Office Visit. **PE:** Tenderness on the right and ROM limited on the right. Normal tenderness. Internal rotation painful. Positive Painful ARC and positive Hawkins test. **Plan:** Start Cyclobenzaprine 8mg. Referred to Orthopedic surgeon.

10/13/2014: MRI Right Shoulder. **Impression:** 1. A large high-grade near full width articular (?) surface partial thickness tear of the supraspinatus junction that involves approximately 70-75% tendon thickness with a thin band of intact articular surface fibers. Small-to-moderate sub acromial/sub deltoid bursal field. 2. Moderate tendinopathy/contusion of the infraspinatus tendon with bursal surface fraying and intrasub_____ partial thickness tearing with _____ to its musculotendinous junction. Mild subscapular is contusions/tendinitis. 3. Mild-to-moderate acromioclavicular joint osteoarthritis with inferior spurring. Lateral down sloping and anterior tilting of the type I acromion abutting the distal posterior supraspinatus tendon with narrowing of the joint space. The findings suggest impingement. Please correlate with physical exam. 4. Tendinopathy of the intra-articular portion of the long head of the biceps tendon. No tear or dislocation. Intact bicipital-labral anchor. 5. No labral tear or paralabral cyst. 6. Grade II sprain at the humeral aspect of the anterior head of the inferior glenohumeral ligament. 7. Mild avulsive-type stress reaction/edema within the greater tuberosity. No fracture. Mild degenerative changes. Small glenohumeral joint effusion.

10/29/2014: Office Visit. **HPI:** Patient had an MRI repeated on 10/18/2014 that confirmed an R RC tear. She is working with restrictions. She is tolerating the Mede that helps with the 5-6/10 pain that is present with use of the RUE above the elbow height. **PE:** Tenderness on the right, ROM limited on the right and weakness on the right but no swelling.

11/04/2014: Orthopedic Evaluation. **PE:** Right shoulder. Markedly restricted ROM. Painful abduction to 80 degrees and flexion to 85 degrees. Tenderness in the anterior acromial region. Positive impingement sign and impingement test. MRI: shows full-thickness tear of the rotator cuff at the attachment site with inferior osteophytes. **Impression:** Acute tear of the rotator cuff of the right shoulder with superior pain and limited function. **Recommendation:** Rotator cuff repair of the right shoulder.

11/11/2014: UR. Rational for Denial: This individual sustained an acute nontraumatic right shoulder injury with the feeling of tearing and MRIs have shown full-thickness with partial width tearing of the supraspinatus tendon with intact anterior and posterior portions making a bridge and preventing retraction; concerns remain that although she has participated in approximately 1 month of supervised PT and some home exercises she still has significantly limited shoulder ROM and there is no report of an opinion by an independent independent orthopaedic surgeons supporting surgical treatment for this individual shoulder, so the medical necessity for proceeding with right shoulder arthroscopy and rotator cuff repair and coracoacromial ligament release is not clearly established.

11/19/2014: UR. Rationale for denial: The request was previously submitted and given an adverse decision. The referenced guidelines note that the criteria for use of a rotator cuff repair include a diagnosis of full thickness rotator cuff tear and cervical pathology and inability to elevate the arm with tenderness over the greater tuberosity. In addition to weakness with abduction and demonstrated positive imagery study of a rotator cuff deficit. There was a lack of complaints of weakness with the abduction testing. Additionally, frozen shoulder syndrome has not been ruled out. As such, medical necessity has not been established.

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 arthroscopy with coracoacromial ligament release and rotator cuff repair.

The patient was injured in xx/xxxx. She has completed two MRI studies of the shoulder, which demonstrated a full thickness tear in the rotator cuff in the absence of muscle atrophy and glenohumeral arthritis. She continues to have limited shoulder motion, weakness, and pain despite extensive conservative care.

The Official Disability Guidelines (ODG) supports rotator cuff repair in patients with objective and subjective findings who have failed 3-6 months of conservative care for a documented rotator cuff tear. Objective findings include weakness, tenderness over the anterior acromion/rotator cuff, positive impingement sign and temporary pain relief following a cortisone injection. The cortisone injection confirms the rotator cuff as a source of pain. This injection is a critical part of the preoperative work-up, as it rules out cervical pathology and frozen shoulder. The patient has not received a cortisone injection to date. She therefore does not satisfy the requirements of the ODG.

Based on the records reviewed, the request for rotator cuff surgery is denied until the patient receives a cortisone injection to the shoulder.

ODG Guidelines:

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)