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June 29, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left shoulder arthroscopic subacromial decompression excision distal clavicle, possible triceps tenodesis, assist surgeon

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

Orthopedic Physician

REVIEW OUTCOME:

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

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 patient is a female who was injured at work on xx/xx/xx. The patient was in the receiving area putting up a box and there was another box on the floor. She bent down to pick up a box and felt a pull in her left back and lower side (hip). The patient admits to left shoulder pain as well.

2014: The patient was seen for left shoulder, left lumbar spine and left hip injury. The patient admitted to tingling in the left hip, radiation of pain in the lumbar spine, a feeling of a pull in the left thigh and knee. The left shoulder had decreased range of motion (ROM) in abduction, external rotation and internal rotation. On physical examination, the left shoulder showed diffuse posterior bicipital groove tenderness. External rotation was 80°, normal internal rotation, normal extension, muscle testing weak, SITS muscles (rotator cuff muscles). Lumbar spine was described as showing full ROM, normal reflexes, sensation decreased on the left in the L3 nerve root distribution. Muscle strength was normal. Sitting straight leg

raising (SLR) was negative, although sitting SLR was reported to be positive on the left. Two views x-rays of the left shoulder were performed and were negative for fracture or dislocation. Four views of the lumbar spine were negative for fracture or dislocation. Left hip x-rays were negative for fracture or dislocation. The diagnoses were sprain of left lumbar, enthesopathy of left hip region and other specified arthropathy in the left shoulder region. Motrin and Flexeril were prescribed and the patient was referred for physical therapy (PT). Per DWC-73, the patient was allowed to return to work as of December 10, 2014, with the restrictions, which were expected to last through December 17, 2014. The patient was allowed light duty work.

From December 12, 2014, through December 19, 2015, the patient attended three sessions of therapy at the .

The patient was seen in follow up on December 15, 2014. It was now indicated that there was a clarification of the injury in that the patient was breaking fall. The patient reported left shoulder was a 10/10. She reported shoulder pain while getting dressed and difficulty washing her hair. There again was no mention of any cervical abnormality. Physical examination assesses her left shoulder claiming that there was diffuse tenderness that was increased, that internal rotation, flexion and external rotation remain the same. The lumbar spine was now noted to be full ROM and under miscellaneous it was claimed that ROM returned to normal. recommended continuing the medications and therapy. The patient was allowed to return to work with the restrictions. The patient was restricted to limit use of left arm and light duty work.

In a follow up on December 19, 2014, the patient stated she wanted to get a second opinion. The patient now stated she had multiple sclerosis and she wanted to see if her symptoms were related to the injury or to her MS (Multiple Sclerosis). She reported she went to her primary doctor and received a steroid injection secondary to losing vision in her right eye. It was noted the patient still complained of shoulder pain rated at 8/10.

The patient was seen in an initial evaluation on December 22, 2014. The patient complained of constant low back pain with left hip pain and paresthesia of left leg. The pain rated at 8/10. She had left shoulder pain, which was rated at 9/10 and associated with intermittent numbness down left arm. The aggravating factors were bending, twisting, lifting, and carrying, prolonged sitting, standing or walking. The relieving factors were rest/heat or medications. Kemp's test was positive bilaterally. Minor's sign, cervical compression and Spurling's test were positive. She was sensitive to palpation of left lumbar paravertebral muscles, especially on left and over the left sacroiliac joint. The cervical flexion was 25 degrees and extension was 35 degrees. She was sensitive to palpation of left cervical paravertebral, left sternocleidomastoid (SCM) and left trapezius muscles. Deep tissue palpation of left cervical paravertebral muscles, SCM, anterior scalene, and trapezius revealed the presence of myofascial trigger points with the characteristic pain referral of pattern of ipsilateral neck, shoulder, and upper back pain. The motor evaluation was graded at +4/5 for bilateral shoulder abduction, elbow

flexion/extension, and wrist flexion/extension and for left hip flexion, bilateral knee flexion/extension, and bilateral ankle dorsiflexion/plantar flexion. The left shoulder ROM was 70 degrees of abduction and 90 degrees of flexion. The DTRs were +2/4 at upper and lower extremities. She was recommended for lumbar. Shoulder and cervical MRI. She was referred to for pain medication consult. She was also recommended for manual therapy, cryotherapy, and home stretching. completed a DWC-73, stating the patient had been prevented from returning from work through January 7, 2015.

The patient was seen in physical therapy (PT) evaluation on December 22, 2014. It was noted that the patient stated she was carrying a box and did not see boxes on the floor where she had put them to build a pallet. The patient stated she stumbled over that box that was on the floor that was empty and she stopped herself from falling by straightening her left arm and catching herself on the empty cardboard box and her arm did not go through the box. The patient stated she had numbness, tingling, to her left hand from incident. The patient also stated she was having severe low back pain and left hip pain. The patient denied any other symptoms. The patient stated her pain increases with her left shoulder with any movement. The patient stated her pain in left hip and back increases with walking or standing. Again, there was no mention of any cervical abnormality. It was noted that she stated her hip felt good but her shoulder was painful. She stated the pain was now 9/10 and 10/10 at times. She reported grabbing and moving boxes at work, lifting her children, combing her hair, showering, getting dressed increases her pain. She stated she wants to get a second opinion because her shoulder hurts so much.

From December 23, 2014, through April 20, 2015, the patient underwent therapy at the consisting of therapeutic exercises, therapeutic activities, electrical stimulation and myofascial release.

2015: On January 7, 2015, saw the patient for follow- up of back pain, left hip pain, and neck pain. She rated her back pain and neck pain at 6/10. She rated sharp shooting radiating left arm pain at 7/10. The lumbosacral ROM is: Flexion with 40 degrees, extension with 14 degrees, left lateral rotation with 10 degrees, and right lateral flexion with 20 degrees. The cervical ROM is: Flexion with 35 degrees and extension with 36 degrees. She was recommended to continue with the same plan as per previous visit. The patient was referred for MRI of the lumbar, cervical, and thoracic spine, upper extremity, and lower extremity. Per DWC-73, the patient had been prevented from returning from work as of 01/07/15 and was expected to continue through 01/28/15.

On January 29, 2015, noted the patient had come for follow- up. She rated her back pain and neck pain at 5/10 and left arm pain at 8/10. She also complained of neck and mid back pain at 5/10. The lumbosacral ROM is: Flexion with 45 degrees, extension with 20 degrees, left lateral rotation with 10 degrees, and right lateral flexion with 20 degrees. The cervical ROM is: Flexion with 27 degrees and extension with 38 degrees. She was recommended to continue with the same plan.

On February 11, 2015, magnetic resonance imaging (MRI) of the left shoulder without contrast was performed. Findings: There was edema within and around the deltoid muscle consistent with contusion or partial tear. A lateral Acromion spur was present as well as spurring at the insertion of the Coracoacromial ligament, which had been associated with impingement. A minimal amount of fluid was present in the subacromial and subdeltoid bursa consistent with bursitis. There was variant anatomy with a Buford complex in the anterior glenoid labrum. Impression: Partial tear contusion of the deltoid muscle and surrounding soft tissues. There was subacromial and subdeltoid bursitis and associated spurring of the acromion. There was variant anatomy of the anterior glenoid labrum.

On February 11, 2015, MRI of the lumbar spine showed: T11-S1: There was minimal loss of disc signal only at these levels. Retrolisthesis were present at multiple levels. There was some edema in the subcutaneous tissues of the mid lumbar region, which may represent contusion or scarring, and correlation with any mechanism of injury was suggested. Impression: Minimal spondylosis change without disc herniation, Contusion versus scarring the subcutaneous tissues mid lumbar region.

On February 20, 2015, performed a designated doctor evaluation (DDE) to determine maximum medical improvement (MMI), impairment rating (IR), extent of injury and work status. The patient complained of severe pain in the left shoulder area. She rated her pain at 6-7/10, difficulty with activities of ADL, using left shoulder. She initially had some neck pain, intermittent pain on the left side of her lower back, between left hip joint and lower back. She rated back pain at 2-3/10. Diagnosis: Left shoulder sprain and strain, left shoulder contusion, and lumbar sprain. The patient had not reached MMI but was expected to reach MMI on or about May 20, 2015. Therefore, IR could not be determined. The extent of injury was limited to left shoulder and lumbar spine. She was capable of returning to the light duty work with limited use of the left shoulder joint or no use of the left shoulder joint. completed a DWC-73 allowing the patient to return to work with restrictions of limited or no use of left upper extremity.

On February 23, 2015, noted the patient had 2/10 pain associated with intermittent numbness down the left arm. The patient was utilizing ibuprofen, cyclobenzaprine and tramadol. referred the patient to orthopedist regarding her shoulder injury and for pain management. She was recommended six additional PT sessions and continuing HEP. She was kept off work pending orthopedic evaluation.

On February 23, 2015, evaluated the patient for injury to neck, left shoulder and lower back. She stated that the Flexeril caused significant drowsiness. The tramadol and Flexeril were effective. She was on work restrictions. diagnosed cervical and lumbar sprain/strain with spasm and left shoulder/rotator cuff sprain. The patient was recommended continuing ibuprofen and tramadol.

On March 10, 2015, the patient continued with ongoing pain. The revised Oswestery score was 46%, NDI 46%, March 10/2015, NDI score were 36%. The patient was recommended continuing current treatment plan and off work status pending orthopedic evaluation.

On April 6, 2015, performed a post DDE RME and certified the patient had reached MMI on April 6, 2015, with an impairment rating of 0% WPI. The extent of injury included cervical sprain/strain and shoulder sprain/strain.

On April 8, 2015, noted the patient needed to leave the country to care for her ailing father. She remained unchanged. recommended referral to orthopedist and obtain nerve conduction study. She was recommended to complete PT session and continue HEP. She was continued off work pending ortho evaluation.

Per a manual muscle strength examination of the cervical spine dated April 8, 2015, the patient rated current pain at 6/10 on left side.

Per an addendum dated April 21, 2015, after reviewing additional records, did not change his previous decision that the cervical injury should not be considered part of the compensable injury.

On April 29, 2015, evaluated the patient for ongoing left shoulder pain rated at 6/10. On examination, the left shoulder revealed tenderness over posterior joint line, AC joint, subacromial space and bicipital groove. The ROM was decreased in all planes. There was mild weakness with resisted external rotation, belly press test and bear hug test secondary to pain. There was positive impingement sign, O'Brien and Mayo shear test. X-rays of the left shoulder revealed type II acromion, otherwise unremarkable. reviewed the MRI dated February 11, 2015, and diagnosed shoulder pain, impingement, possible superior labrum anterior to posterior lesion and derangement AC joint. recommended arthroscopic subacromial decompression, excision distal clavicle and possible biceps tenodesis left shoulder of left shoulder. The patient agreed to proceed.

Per a reconsideration review dated May 6, 2015, the request for left shoulder arthroscopic subacromial decompression excision distal clavicle, possible triceps tenodesis, and assist surgeon was denied with the following rationale: *"Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced above, this request is non-certified. There was lack of documentation that adequate conservative care was exhausted prior to the surgical request. There is also a lack of documentation the patient had pain with active arc motion of 90 degrees to 130 degrees, or has utilized anesthetic injections/diagnostic injection test for temporary relief of pain. There was also lack of a bone scan indicating positive AC joint separation, along with changes in the acromioclavicular joint. Furthermore, there was lack old documentation to indicate the patient had a type 2 or type 4 lesions to warrant a biceps tenodesis. As the surgical request is not supported, the ancillary request for a surgical assistant and preop medical clearance will also not be warranted or supported at*

this time. In addition, there was a lack of documentation to indicate a medical necessity for an assistant surgeon in an arthroscopic procedure.”

On May 7, 2015, noted the patient had sharp, shooting radiating pain to her left arm with coughing, sneezing and bearing down. recommended referral to for her left shoulder surgery. She was also recommended nerve conduction study and continuing HEP. The patient was kept off work pending orthopedic surgery.

A manual muscle strength examination of the shoulder was performed on May 7, 2015, that revealed the patient had pain score of 5/10 in the left shoulder.

Per utilization review dated May 28, 2015, the request for Left shoulder arthroscopic subacromial decompression excision distal clavicle, possible triceps tenodesis, and assist surgeon was denied with the following rationale: *“Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced above, this request is non-certified. The documentation failed to provide evidence of pain with active arc of motion of 90 degrees to 130 degrees or s prior diagnostic injection with temporally relief. There was also no documentation indicating the patient had a type 2 or type 4 lesions to warrant a biceps tenodesis. Therefore, the request is not supported. Given the requested surgical procedure was not supported, the request for an assistant surgeon and preop medical clearance are also not supported.”*

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

The request is for a left shoulder arthroscopic subacromial decompression, distal clavicle resection, and possible triceps tenodesis with an assistant surgeon. Most likely, this is an error; and they are requesting a biceps tenodesis. There is no documentation that this individual has been treated with an injection and the extent of therapy regarding the shoulder is poorly-documented. Although she may have impingement, there is no documentation of the acromioclavicular joint being a pain generator. Without speaking to the physician, there is limited information to support the procedure. This individual has had rather extensive subjective complaints. It is unknown if the shoulder is the source of the pain. There is no documentation of conservative treatment being exhausted with an injection or positive impingement test. There is no documentation of the acromioclavicular joint being a source of pain.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

IF YOU ARE NOT UTILIZING THE ODG GUIDELINES YOU MUST STATE WHY, PER TEXAS DEPARTMENT OF INSURANCE.

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines (20th annual edition) & ODG Treatment in Workers' Comp (13th annual edition), 2015

Shoulder Chapter - acromioplasty, partial claviclectomy, and biceps tenodesis.

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 MRI, ultrasound, or arthrogram shows positive evidence of impingement.

(Washington, 2002)

Partial Claviclectomy, Mumford Procedure

Criteria for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint:

1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS
2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS
3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS
4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation.

Criteria for Surgery for Biceps tenodesis:

- After 3 months of conservative treatment (NSAIDs, PT)
- Type II lesions (fraying and degeneration of the superior labrum, normal biceps, no detachment)
- Type IV lesions (more than 50% of the tendon is involved, vertical tear, bucket-handle tear of the superior labrum, which extends into biceps, intrasubstance tear)
- Generally, type I and type III lesions do not need any treatment or are debrided
- Also patients undergoing concomitant rotator cuff repair
- History and physical examinations and imaging indicate pathology
- Definitive diagnosis of SLAP lesions is diagnostic arthroscopy
- Age over 40 (otherwise consider SLAP repair).