

# Medical Assessments, Inc.

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## **IRO CASE #:**

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

Right Shoulder Arthroscopy SAD 29826, Contracture release 23020, 29825, Glenohumeral joint debridement 23020, 29821, 29823, and 29819

### **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 due to lifting. She was diagnosed with status post right shoulder arthroscopy, partial synovectomy, biceps tenotomy, openacromioplasty, rotator cuff repair, and bicep tenodesis.

07/02/2013: Office visit. HPI: Claimant reported burning and pain in the shoulder. Also reported pain at night interfering with sleep. Weakness and stiffness in shoulder. **Medications:** Gabapentin, Hydrocodone-Acetaminophen, Lisinopril.

07/31/2014: Office visit. **Office X-rays:** Impression: R Shoulder / Arm: S/P RCR in Nashville. Rotator cuff tear. Postoperative shoulder stiffness.

10/13/2014: Office visit. ROM: Forward Flexion= 120 degrees. Abduction = 120 degrees. External rotation with the arm at side = 40 degrees.

01/05/2015: MRI UP JNT W/CONT RT. 1. There is a partial-thickness recurrent interstitial and undersurface tear of the anterior aspect distal supraspinatus tendon. No evidence of full-thickness recurrent rotator cuff tear. 2. No MR evidence of labral tear.

01/22/2015: Office visit. Cortisone injection given previously relieved symptoms of pain and discomfort for a few weeks. **Plan:** Rest. Activity modification. PT.

03/23/2015: Office visit. Claimant reported no symptom changes since previous visit. PE: Claimant was noted to have diffuse tenderness, without specified localized tenderness. Her incisions were noted to be clean, dry and without evidence of infection. There was no swelling. Active ROM to be 120 degrees of forward flexion and abduction, and 40 degrees of external rotation with arm at side.

04/02/2015: Progress Notes. Claimant reported pain located in the right shoulder. Pain was a 7/10. The pain is improved by medications, and lying down.

05/04/2015: UR. Rationale for denial: The patient is a female who reported an injury on xx/xx/xx. The mechanism of injury was due to lifting. Her diagnoses include right shoulder stiffness. The clinical documentation submitted for review indicated the patient failed 3 to 6 months of conservative care including physical therapy and injection to the shoulder. There was no documentation noting positive impingement sign. Given the lack of physical examination findings, the request is not supported by the evidence based guidelines. As such, the request for surgical request; right shoulder arthroscopy SAD 29826, contracture release 23020, 29825, glenohumeral joint debridement 23020, 29823, 23919 is non-certified.

05/28/2015: UR: Rationale for denial: The patient is a female who reported an injury on xx/xx/xx. The mechanism of injury was lifting. She was diagnosed with status post right shoulder arthroscopy, partial synovectomy, biceps tenotomy, openacromioplasty, rotator cuff repair, and bicep tenodesis. A request was previously submitted and non-certified due to no indication that the patient had pain with active arch motion 90 degrees to 130 degrees and pain at night. There was no documentation noting positive impingement sign.

06/02/2015: Progress notes. Claimant reported pain 7/10. The pain is described as burning-aching a spasm. The pain radiates down the arm. The timing of the pain is continuous. **Medications:** Metoprolol Tartrate, Gabapentin 300mg, Norco 10-325 mg, Melatonin, Prozac.

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

The request for right shoulder arthroscopy, subacromial decompression, contracture release, and glenohumeral joint debridement is denied.

The patient continues to have pain in the shoulder following a rotator cuff repair with biceps tenodesis. She has limited active motion on examination. Her recent MRI documents an intact rotator cuff with a partial tear of the anterior supraspinatus tendon.

The physical examination does not indicate whether she has a positive impingement sign. The patient's passive range of motion is not documented either. It is unclear whether her pain is due to the partial tear versus a contracture of the joint.

An intra-articular injection of cortisone is recommended prior to consideration of surgery. If her primary issue is contracture of the joint, a dynamic splint may also be considered.

The records reviewed do not support the requested surgical procedure.

ODG:

Recommended as indicated below. **Criteria** for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear

**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)**