

Medical Assessments, Inc.

4833 Thistledown Dr.
Fort Worth, TX 76137
P: 817-751-0545
F: 817-632-9684

Notice of Independent Review Decision

February 18, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient ASC Left Shoulder Rotator Cuff Repair 23412

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:

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 that reported an injury on xx/xx/xx when he slipped and fell and tried to stop the fall. He was diagnosed with a left shoulder rotator cuff tear.

07/31/2014: Evaluation. **HPI:** The claimant stated that his current orthopedic problem involves an injury to his right and left shoulder. The claimant maintains that the problem originally started after an injury at work. **Medications:** Omeprazole, Simvastatin, Benazepril, Metoprolol.

07/31/2014: Evaluation. **Exam:** Both shoulders are at 90 degrees of palm down abduction; it hurts about the same palm up. He does not like moving it above that, but can bring the arm up to 160 degrees of forward flexion, bilaterally, but it is painful. There is a palpable defect at the greater tuberosity on the right, a little less on the left. There is tenderness over the biceps tendon sheath and

significant muscle spasm along the levator scapulae and upper trapezial fibers. An impingement test is positive, bilaterally, worse right than left. A SLAP lesion test is positive, bilaterally, worse right than left. There is a reproducible click at the apex of circumduction, bilaterally, worse right than left as well. **Impression:** Superior labral injury both shoulders with questions of rotator cuff tears. **Plan:** Need a contrasted MRI of both shoulders to determine whether this needs to be repaired or has a potential for healing on its own. Wall climbing exercises are advocated to prevent stiffness.

09/02/2014: MRI of left shoulder. **Impression:** Small, full-thickness tear of the supraspinatus tendon. Postsurgical changes of the Glenoid Labrum. Intact appearing labrum.

09/18/2014: Evaluation. **Impression:** 1. Symptomatic SLAP lesion right shoulder with erosion of the rotator cuff and A/C joint arthritis. 2. Left shoulder, new tear of the rotator cuff, small. **Plan:** Process with the right shoulder first since we cannot do both the same day. The right shoulder needs a subacromial decompression and Mumford procedure, SLAP lesion repair and possible imbrication of the rotator cuff.

11/13/2014: Evaluation. **Exam:** There is a lot of ecchymosis as would be expected at this point. **Plan:** Started home exercise and PT on December 3rd. Reassess in 10 weeks; however, left shoulder has a hole in the rotator cuff. The right shoulder has a new hole in the rotator cuff that was not visible with the last arthroscopy; therefore, it is related to the new injury falling off the pump truck.

12/23/2014: Notes. **X-rays:** Show no avulsion fractures, shows a Type I configuration of acromion, a good Mumford gap, the humeral head is well centered in the glenoid socket. There is no superior migration, no medial migration. These are normal postoperative films. **Plan:** Slow down the lateral deltoid strengthening until the muscle calms down, but he can still work on his motion and strength otherwise, and the left shoulder will be taken care of as soon as we can get the approval.

12/23/2014: UR. Rationale for denial: The patient is a male who reported an injury on 7/17/2014 when he slipped and tried to stop his fall. The patient is currently diagnosed with a left shoulder rotator cuff tear. A request was made for out-patient left shoulder rotator cuff repair. While it is noted that the patient is symptomatic regarding the left shoulder, there is a lack of documentation showing that the patient has undergone at least 3 to 6 months of conservative care directed towards the left shoulder to support the request. In the absence of this information, the request would not be supported by the evidence based guidelines. As such, the request is non-certified.

01/27/2015: UR. Rationale for denial: The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The patient is a 52-year-old male who reported an injury on 7/17/2014. The mechanism of injury was a slip and fall. Diagnoses include rotator cuff (capsule)

sprain. Medications were not provided. Surgical history included subacromial decompression and Mumford procedure and SLAP lesion repair. In the absence of care directed towards the left shoulder to support the request. In the absence of the information, the request would not be supported. The medical necessity of the request has not been established and the previous determination is upheld. As such, the request is non-certified.

01/29/2015: Evaluation. **Exam:** Posture is off, both shoulders, leaning forward there is lateral impingement on the right side due to an acromial edge wearing in spite of the removal of bone spurs, both in the forward lateral position, mostly lateral in the midrange abduction between 80 and 120 degrees, worse palm down than palm up, implicating and impingement problem.

The left shoulder has weakness at 90 degrees and above, both in functional abduction and forward flexion. It is easily overcome 4 out of 5 strength, which is unusual for him. Impingement test is positive, there is a small click felt in circumduction where the edge of the rotator cuff is getting caught. **Plan:** He has been terminated from his job. He has developed a hole in the muscle documented after falling off a pump truck. This is a new injury. It is not something old he is living with, it is not a recurrent problem, it is entirely new since he had no hole in the rotator cuff to begin with but has one now. He needs surgery. Will have him work on his posture in the meantime to make him feel better.

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

The previous adverse determinations are upheld. There is a lack of documentation pertinent to his left shoulder regarding treatment or therapy. ODG guidelines recommend the patient to have ROM and strengthen exercises. This therapy regimen should be carried out before surgery is recommended, if necessary. Therefore, the request for Outpatient ASC Left Shoulder Rotator Cuff Repair 23412, is non-certified.

ODG:

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)