

# AccuReview

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**[Date notice sent to all parties]:** October 6, 2015

**IRO CASE #:**

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

Left Shoulder Diagnostic Arthroscopy 29805

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

This physician is Board certified in Orthopaedic Surgery with over 14 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 in a work related injury. She reported she was walking in the parking lot when she accidentally stepped into a hole and fell forward, landing onto her left side. She twisted her left knee and ankle, and also injured her left shoulder and left wrist when she tried to brace the fall with her outstretched left upper extremity. Her low back struck pavement. Claimant reported that she injured her neck, low back, left shoulder, left wrist, left knee, and left ankle region.

xxxxxx: Initial Comprehensive Evaluation. CC: LBP, Left shoulder pain, left wrist pain, left knee pain, left ankle pain, left foot pain. The claimant stated that she is experiencing pain in the area of lumbar spine. She described it as constant severe stiffness and inflexibility and restricted movement and tingling sensations as well as stinging pain migrating to the buttocks and left posterior thigh. She stated that she has noticed an increase on the degree of LBP from lifting, pulling, pushing, bending, carrying and sitting. She reported that she has been experiencing left shoulder pain. This is further described as constant severe stiffness and inflexibility and restricted movement and tingling sensations and numb sensations as well as achy, sharp and shooting pain migrating to the left arm. The claimant stated that repetitious movements appears to increase her degree of left shoulder pain and there is pain in the area of the left wrists. This is further described as constant severe stiffness and tingling sensations as well as stinging pain left forearm. PE: Flexors of the shoulder: The test for the flexor muscles of the shoulder is the claimant flexes the elbow to 90 degrees and the examiner wraps finger around the anterior aspect of the claimant's arm and biceps muscle. The examiner then instructs the claimant to begin flexion of the shoulder as the examiner increases the resistance to determine the maximum resistance the claimant can overcome. Weakness of this muscle test can indicate deconditioning of the muscles involved with flexion of the shoulder, anterior portion of the deltoid and coracobrachialis. This muscle test could also indicate the presence of a lesion of the nerves innervating these muscles

(anterior deltoid – C5 [axillary nerve]; coracobrachialis – C5, C6 [musculocutaneous nerve]). The muscle test on the right was graded 5/5. The muscle test on the left was graded 3/5. Assessment and Plan: 722.10 Displacement of Lumbar Intervertebral Disc without Myelopathy, 726.10 Disorders of Bursae and Tendons in Shoulder Region, Unspecified, 727.05 Other Tenosynovitis of Hand and Wrist, 717.9 Unspecified Internal Derangement of Knee, 718.97 Unspecified Derangement of Ankle and Foot Joint, 729.2 Neuralgia, Neuritis, and Radiculitis, Unspecified, 728.89 Other Disorders of Muscle, Ligament, and Fascia. The claimant is suffering acute symptoms. The following is the treatment plan for the claimant. Kinetic mobilization therapy will be administered to the left posterior shoulder area left anterior shoulder area, left foot, left ankle, left knee, left wrist and lumbar area. This treatment is given to increase functional mobility, manual therapy will be administered to the left posterior shoulder, anterior shoulder region on the left, left foot, left ankle, left knee, left wrist region and area of the low back. To improve functional joint mobility, direct one-on-one therapeutic exercise will be administered to the posterior left shoulder area, left anterior shoulder, left foot, left ankle, left knee, left wrist area and lumbar region. Treatment will consist of neuromuscular reeducation to the left posterior shoulder, left anterior shoulder area, left foot, left ankle, left knee, wrist on the left posterior shoulder, left anterior shoulder area, left foot, left ankle, left knee, wrist on the left and region of the low back, in order to retrain the affected musculature to increase mobility and strength. Medications: Lodine, Flexeril, Ultram.

04-09-13: MRI of the Left Shoulder. Impression: 1. Grade 1 tenosynovitis of the long head of the biceps, 2. Small left glenohumeral joint effusion, 3. Mild distal supraspinatus tendinosis, 4. Type II acromion process.

04-18-13: Post Designated Doctor's Required Medical Examination. The claimant's significant problem at this time is the surgical repair of the anterior cruciate ligament. She has been doing therapy for four weeks which is approximately 12 sessions. Therefore, I would state she should be at MMI on or about 7/01/2013.

10-14-13: Office Visit. The claimant stated her pain in the left shoulder is slightly more severe than last visit with other complaints. Objective: Left shoulder: edema in left shoulder, soft tissue palpation hypertonicity: moderate, tenderness: severe, bony palpation left shoulder tenderness: severe. DX: 726.1 rotator cuff syndrome of shoulder and allied disorders, ... 726.10 disorders of bursae and tendons in shoulder region, unspecified, ... Assessment: The claimant has reached a subacute status. Plan: The claimant's condition has shown some improvement and has entered a subacute phase. In order to improve functional motion, direct doctor-patient kinetic activity was administered to the left hand, left wrist area, left ankle, posterior left shoulder area, left anterior shoulder area, lumbar area and left knee. Treatment included direct one-on-one therapeutic exercise to the left ankle, hand on the left, wrist on the left, posterior shoulder region on the left, left anterior shoulder area, region of the low back and left knee to provide an increase in functional joint mobility. Treatment consisted of neuromuscular reeducation to the left hand area, wrist on the left, left ankle, left posterior shoulder, anterior shoulder region on the left, area of the low back and left knee. The purpose is to retrain the affected musculature to increase mobility and strength.

04-02-14: Transcription. CC: left shoulder pain 8/10, unchanged. The problem is made better by rest and medication, made worse by exercise and movement and unchanged by eating food and sleeping. DX: sprain knee.leg, uns internal derangement knee, sprain/strain of wrist, sprain/strain rotator cuff, sprain/strain lumbar region, sprain/strain of ankle uns. Medications: Tramadol 50mg, Mobic 15mg. Plan: F/U, ordered PT – continue RE: request by for post manipulation under anesthesia PT, for duty with restrictions starting 3/6/14. Recommend a FCE to address return to work with restrictions and recommendations. Claimant needs a heat pack for home and cervical pillow if authorized. Referral to pain.

05-01-14: Office Visit. CC: f/u left shoulder. C/O left shoulder pain and decreased motion especially with overhead use. PT x done pre and post surgery and MUA. Injection prior to surgery. Surgical hx: left shoulder arthroscopy 08/20/2013, left shoulder MUS 01/21/2014. Medications: Norco 7.5/325, Tramadol 50mg. Assessment: sprain of shoulder NOS 840.9, sprain of knee NOS 844.9. Plan: Claimant's ROM hasn't improved since MUA 01/2014 and she continues with increased pain. Will give cortisone injection of shoulder to see if it will offer pain relief to breakthrough in PT.

05-22-14: Office Visit. CC: F/U left shoulder. Follow up after cortisone injection and stated it helped for about a week but pain returned. 80 hours work hardening not beneficial and made pain worse. Objective: left shoulder: ROM:

active forward elevation @ 100 degrees. Strength testing: 3/5 all RTC groups. Palpation: tenderness over proximal humerus, tender over the bicipital groove, tenderness subacromial space, + jobs, cross-arm test positive, impingement sign positive. Tests: positive NEER, positive yergeson, positive Speed. Assessment: sprain of knee NOS, sprain of shoulder NOS. Plan: F/U 4 weeks.

06-12-14: MRI Left Shoulder Arthrogram with Contrast. Impression: 1. Technically limited examination from metallic susceptibility artifact from the claimant's previous shoulder surgery. 2. Type II acromion process. 3. Consider a CT shoulder arthrogram for further evaluation.

06-19-14: Office Visit. CC: F/U left shoulder/MR arthrogram. Objective: left shoulder: ROM: active forward elevation significantly less than passive @ 0-90 degrees, left positive drop arm test. Palpation: Hawkin's sign positive, cross-arm test positive, impingement sign positive, tenderness over proximal humerus, tenderness subacromial space, tender over the bicipital groove, + Jobs. Tests: positive speed, positive yergeson, positive NEER. Assessment: sprain of shoulder NOS. Plan: Unfortunately MR Arthrogram was very limited due to artifact. Exam findings are consistent an suspicious of recurrent rotator and SLAP derangement. She had recent ER visit due to pain. She did not respond to post op PT and had short term benefit from post op cortisone injection and increased pain and decreased ROM after MUA. Claimant wants to proceed with Left shoulder diagnostic scope.

09-11-14: Office Visit. CC: F/U left shoulder (per DB SX to IRO waiting on decision). PE: left shoulder: ROM: active forward elevation significantly less than passive 0-90 degrees, left positive drop arm test. Strength testing 3/5 all RTC groups, breakaway weakness is present on testing. Palpation: Hawkin's sign positive, cross-arm test positive, impingement sign positive, tenderness over proximal humerus, tenderness subacromial space, tender over the bicipital groove. Tests: positive jobs, positive Apleys. Assessment: sprain of knee NOS, sprain of shoulder NOS. Plan: Original surgical request of left shoulder diagnostic scope with possible open RCR was denied on rationale of imaging did not support guidelines for open RCR procedure. The gold standard MR Arthrogram of left shoulder dated 6/12/2014 was technically limited due to metallic susceptibility artifact from previous left shoulder surgery. The inconclusive imaging and exam findings that are consistent with cuff and glenohumeral joint derangement do meet the ODG criteria for Left Shoulder Diagnostic Arthroscopy. She didn't respond to post op PT and had short term benefit from post op cortisone injection and increased pain and decreased ROM after MUA. Claimant wants to proceed with left shoulder diagnostic scope.

10-30-14: MMI. Summary: Based on the mechanism of injury as described by the claimant, the fall on was a substantial contributing factor in causing her low back injuries, resulting in lumbar disc displacements of 4mm disc protrusion at L5/S1, 3mm protrusion L4/L5, and 3mm protrusion at L3/L4. The claimant reported that she accidentally stepped into a hole in the parking lot, twisted her left ankle and left knee, and fell down with the left side of her body striking the pavement, including her lumbar region. Falling onto the concrete pavement on her low back, within a reasonable degree of medical probability, can bring about compressive forces to the lumbar disc. The compressive forces to the lumbar disc can stress the disc's tough outer cartilage layer beyond its normal physiological limits, causing some of the softer inner cartilage layer to protrude out of disk. Herniated discs are often the results of injuries that asymptomatic before the accident; it is my opinion that there is a causal relationship between the accident and her present lumbar disc conditions. Therefore, based on the examination and review of medical records, I conclude that the accident on was a substantial contributing factor to the claimant's condition of lumbar disc displacement (722.10). The claimant had reached statutory MMI as of 10/30/2014.

11-06-14: DWC Designated Doctor Evaluation. Left shoulder impairment: 7% shoulder uncombined, 7% Whole Person Impairment. Impairment summary: wrist 10%, shoulder 7%, lumbar 5%, knee 4%, and Ankle 0%.

03-19-15: Office Visit. CC: F/U left shoulder. PE: left shoulder: ROM: active forward elevation and abduction significantly less than passive. Strength testing: 3/5 all RTC groups, breakaway weakness is present on testing. Neck exam: tenderness, spasms over trapezium muscle. Assessment: sprain of knee NOS, sprain of shoulder NOS.

05-21-15: Office Visit. CC: F/U left shoulder. PE: left shoulder: inspection: guarded postures. ROM: active forward elevation = 0-110 and abduction = 0-100 with audible pop @ 90 degrees. Strength testing: 1-3/5 all RTC groups,

breakaway weakness is present on testing. Palpation: tenderness over proximal humerus, tender over the bicipital groove, tenderness over long head of biceps and biceps, impingement sign positive, labral click test positive. Stability test: ant. Apprehension positive. Neck exam: tenderness over trapezium muscle. Tests: positive Apleys, positive Jobes, positive O'Briens, positive Infrapinatus test, positive Hawkin's. Assessment: sprain of shoulder NOS. Plan: claimant lacks any progress with last cortisone injection. Today she presented with symptoms consistent with cuff and labral insufficiency. Recommending CT Arthrogram left shoulder to rule out derangement to form appropriate treatment plan. F/U 4 weeks.

06-30-15: CT of the Left Shoulder Arthrogram with Contrast. Impression: 1. Moderate calcific distal supraspinatus tendinitis. 2. Type 2 acromion process. 3. Multiple metallic anchoring devices in the greater tuberosity of the humerus from remote rotator cuff tendon repair. 4. There has been no significant change in the CT appearance of the left shoulder from December 9, 2014.

07-09-15: Office Visit. CC: F/U left shoulder CT arthrogram. PE: left shoulder: inspection: guarded postures. ROM: active forward elevation = 0-110 and abduction = 0-100 with audible pop @ 90 degrees. Strength testing: 3/5 all RTC groups, breakaway weakness is present on testing. Palpation: tenderness over proximal humerus, tender over the bicipital groove, tenderness over long head of biceps and biceps, impingement sign positive, labral click test positive. Stability test: ant. Apprehension positive. Tests: positive Apleys, positive Jobes, positive O'Briens, positive Hawkin's. Assessment: sprain of shoulder NOS. Plan: claimant has attempted and failed conservative treatments of medications, activity modifications, prior surgery, pre and post op PT and cortisone injections but continues with symptoms of constant sharp, throbbing pain that contributes to loss of motion and inability of overhead or above shoulder use consistent with rotator cuff insufficiency/derangement. Claimant reported night pain and is unable to sleep on left shoulder. Significant abnormal findings of 06/30/2015 CT Arthrogram. Claimant exam and debilitated use of arm prompts treatment to restore functional use of arm. Explained in detail surgical procedure of diagnostic arthroscopy and potential risks explained. Recommending Left shoulder Diagnostic Arthroscopy in effort to regain function and begin rehabilitation process in effort to expedite claimant's return to regular duties and daily activities. Will also proceed with cortisone injection of left shoulder today for pain relief.

08-05-15: UR. Reason for denial: 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 claimant's history, physical examination findings, and radiographic findings are consistent. The CT findings were conclusive and a diagnostic arthroscopy would not be medically necessary at this time. It was not specified as to how the requested diagnostic arthroscopy would alter or benefit the claimant's treatment plan going forward.

09-09-15: UR. Reason for denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Although the claimant has persistent pain and functional limitation despite conservative treatment with PT, medications and injection, there is no indication that the recent left shoulder CT arthrogram dated 06/30/15 was inconclusive to warrant diagnostic arthroscopy of the left shoulder. The CT findings were conclusive and a diagnostic arthroscopy would not be medically necessary at this time.

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

The previous adverse determinations are upheld and agreed upon. The request for diagnostic arthroscopy of the left shoulder is denied. The Official Disability Guidelines (ODG) supports a diagnostic arthroscopy of the shoulder in the patient with inconclusive imaging and acute pain or function limitation despite conservative care. This claimant continues to have pain and weakness in the shoulder following an work injury. The recent MRI arthrogram and CT arthrogram of the shoulder have conclusively demonstrated an intact rotator cuff, following a prior rotator cuff repair. The biceps tendon and labrum were unremarkable in these studies. The medically necessary for the proposed procedure is not clear based on the records reviewed. Therefore, after reviewing the medical records and documentation provided, the request for Left Shoulder Diagnostic Arthroscopy 29805 is denied.

Per ODG:

Diagnostic arthroscopy	Recommended as indicated below. <b>Criteria</b> 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 href="#">Washington, 2002</a> ) ( <a href="#">de Jager, 2004</a> ) ( <a href="#">Kaplan, 2004</a> ) For average hospital LOS if criteria are met, see <a href="#">Hospital length of stay</a> (LOS).
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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)