True Decisions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 1/8/2019 10:28:44 AM CST

True Decisions Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #615
Mansfield, TX 76063
Phone: (512) 298-4786
Fax: (888) 507-6912
Email: manager@truedecisionsiro.com

IRO REVIEWER REPORT

Date: 1/8/2019 10:28:44 AM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX scope limited XX XX XX open XX

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

REVIEW OUTCOME:

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]: XX. XX XX is a XX XX who tripped over XX at work on XX. XX injured XX XX XX, elbow and knee. XX. XX was evaluated by XX on XX for chief complaints of XX XX pain, XX elbow pain, and XX knee pain. XX complained of diffuse pain, weakness, swelling, and stiffness. The severity of XX symptoms was XX. The quality of pain was dull / aching and throbbing. XX symptoms had worsened. XX reported XX could not sleep on the XX, it hurt to do XX XX, and XX had difficulty reaching for XX XX in XX XX pocket or fastening XX XX, and weakness with overhead activities. On examination, the XX shoulder showed tenderness to palpation at the greater XX, range of motion 0 to 90 degrees, inability to abduct beyond XX degrees, weakness with internal and external rotation, and XX drop arm test. The XX elbow was diffusely tender with diffuse swelling and limited range of motion secondary to pain. XX hand showed weakness secondary to pain. The XX knee showed diffuse tenderness with diffuse XX and mildly limited range of motion

secondary to pain. The diagnoses included XX XX strain, XX knee XX, XX elbow XX, and closed nondisplaced fracture of greater XX of the XX humerus. XX. XX would remain off work due to persistent pain and lack of functional abilities. An MRI of the XX shoulder to rule out rotator cuff tear was ordered. A XX shoulder immobilizer was placed. XX and XX were continued. Work excuse was provided, and XX. XX was to remain off work due to persistent pain and lack of functional abilities. On XX, XX. XX reported no change in XX symptoms. XX had clicking with throwing or overhead activities. XX shoulder examination additionally showed XX apprehension test with pain with XX / XX shift and positive XX test with deep-seated XX with movement. XX elbow examination was within normal limits. The diagnoses were XX XX XX and detachment of the XX XX XX. Prescriptions for XX and XX gel were given. XX off-work status was continued. On XX, XX. XX was evaluated by XX for chief complaints of XX shoulder pain, XX shoulder sprain / strain, and XX biceps pain. Since the prior visit, XX. XX's symptoms had worsened. At the time, pain was located in XX XX shoulder. XX symptoms were diffuse pain, pain with motion, weakness, swelling, and stiffness. The symptoms were severe, sharp, dull / aching, and throbbing. On examination, the XX shoulder showed tenderness to palpation at the greater XX. The range of motion was 0 to 90 degrees with an inability to abduct beyond XX degrees. There was weakness with internal and external rotation. A positive drop arm test was noted. Tenderness and swelling were present of the XX XX arm. XX hand showed weakness secondary to pain. Assessment included XX of the XX XX, closed nondisplaced fracture of greater XX or XX humerus, detachment of XX XX XX, and XX XX XX strain. The plan was to proceed with surgery. XX was placed on modified duty with pushing / pulling / overhead reaching for zero hours. Per the XX note, XX. XX's symptoms had worsened. XX shoulder examination noted diffuse tenderness, full range of motion, XX/5 strength of all muscles, positive apprehension test, pain with anterior / posterior shift, and positive XX's test, deep-seated click with movement. There was XX XX arm tenderness and swelling noted. An additional diagnosis was biceps XX of the XX shoulder. XX. XX was continued on modified duty. XX evaluated XX. XX on XX for XX biceps pain. At the time, the pain was located in XX XX XX and XX shoulder. The ongoing symptoms were diffuse pain, weakness, swelling, and stiffness. The symptoms were severe, sharp and throbbing. This problem was related to a XX injury. The compensable body parts covered under this XX claim were XX XX and XX shoulder and the injury occurred on XX. XX. XX's ongoing work status was modified duty. On the prior visit, XX had prescribed medications and recommended a home exercise program. There had been improvement with medications. XX XX examination showed tenderness present over XX, limited range of motion in all planes secondary to pain, weakness secondary to pain, and increased tone / stiffness, spasm present by palpation. XX shoulder examination showed anterior tenderness over the XX groove and pain at the XX with resistance of XX of elbow. XX XX arm showed tenderness with swelling. XX was placed on modified duty with pushing / pulling / overhead reaching for zero hours and no lifting / carrying more than XX pounds. On XX, XX shoulder / humerus x-rays showed healing fracture with acceptable alignment. On XX, MRI of the XX shoulder showed greater XX fracture with minimal displacement and associated bone marrow edema, XX, rotator interval tear and XX, XX, XX, and mild XX. Treatment to date included medications, XX physical therapy sessions (with improvement), home exercise program, XX shoulder immobilizer, off-work status and then modified duty work status. Medications included XX, XX, XX, XX, XX, XX, XX, XX-XX. There had been improvement with medications. Per XX dated XX by XX, the request for XX shoulder scope with limited XX, XX, XX, and open XX, was non-certified. Per Analysis and Clinical Basis for Conclusion, XX. XX reported continued discomfort and limitations with reaching activities. XX reported about XX% overall functional improvement with prior physical therapy sessions. On physical examination, there was tenderness noted in the XX, XX, and XX. However, proactive testing on examination was negative. There was no clear indication that XX. XX had trialed an anesthetic injection with temporary relief of pain. Pathology noted on MRI was minimal. Therefore, the request for XX shoulder scope with limited debridement, XX, XX, and open XX was non-certified. Per XX XX by XX, the appeal request for XX shoulder scope with limited debridement, XX, XX, and open XX was non-certified. Per Analysis and Clinical Basis for Conclusion, regarding the request, surgery was previously denied due to minimal findings on imaging and no evidence of positive orthopedic tests as well as no evidence of a prior diagnostic injection. Although an updated clinical note was provided for review dated XX, indicating that XX. XX did have positive findings on examination including positive XX's test, positive XX test, and pain with XX / XX shifting, there was still no description of a prior diagnostic /

therapeutic injection, as required by guidelines. There were no documented contraindications to an injection. Therefore, XX shoulder scope with limited XX, XX, XX, and open XX was non-certified.

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

The ODG recommends arthroscopic XX as an alternative to shoulder arthroplasty for XX or for the treatment of labral tears following a failure of XX. The ODG does not recommend surgery for XX as an isolated procedure and recommends at XX of conservative treatment unless earlier surgical criteria for other associated shoulder diagnoses are met. The criteria include functional impairment persisting at least one year, pain with active arc of motion, pain at night, tenderness over the rotator cuff or XX, positive impingement signs, temporary relief of pain with a diagnostic injection, and imaging findings of impingement. The ODG recommends XX when there is pain at the XX joint, tenderness over the XX joint and/or pain relief obtained with a diagnostic injection, imaging findings of posttraumatic changes or XX of the XX joint, and a failure of at least six weeks of conservative treatment. The ODG recommends surgery for biceps XX for the treatment of XX when there has been a failure of three months of conservative treatment including NSAIDs, injection, and physical therapy. The provided documentation reveals evidence of persistent XX shoulder pain and functional limitation approximately XX months out from injury despite treatment with activity modification, NSAIDs, and XX visits of physical therapy. It is noted that there was improvement with physical therapy and it is unclear why only five visits of physical therapy were completed. There is no evidence of any diagnostic or therapeutic injections. In addition, while there are MRI findings of a partial tear of the biceps XX, XX, and mild XX, the only abnormal finding on the physical examination of the XX shoulder from the most recent note dated XX, XX is XX tenderness over the bicipital groove. There is no evidence of tenderness over the rotator cuff or XX, positive impingement signs, or tenderness over the XX joint. Given the lack of diagnostic and therapeutic injection and lack of pertinent objective findings, the requested procedures are not supported. Recommendation is for upholding the two previous denials.

Given the documentation available, the requested service(s) is considered not medically necessary and the decision is upheld.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

True Decisions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 1/8/2019 10:28:44 AM CST

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

ODG, 2018: Shoulder