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January 7, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX surgery

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Orthopaedic Surgeon (shoulder subspecialist)

REVIEW OUTCOME:

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

X 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 patient is a XX-year-old XX who alleges injury on XX, when XX was XX. XX felt a pop and sharp pain in XX XX XX.

On XX, a magnetic resonance imaging (MRI) of the XX XX was performed at XX, interpreted by XX. The study showed a full-thickness tear of the XX tendon with fluid continuing through the tear into the XX. There was XX of the XX tendon along the XX aspect of the XX shoulder.

On XX, the patient was seen by XX, in an initial evaluation. The claimant stated XX days after the injury XX was seen at XX where x-rays were obtained which showed no fracture or dislocation. XX had been treated with muscle relaxants and NSAID, and XX had completed about XX sessions of formal therapy with no improvement. Currently, XX complained of severe XX pain in the XX XX mainly with activities accompanied by popping, catching/locking, weakness and limited motion

mainly with external rotation. XX also had numbness and tingling in XX XX hand/fingers. The XX shoulder MRI showed a XX-thickness tear of the XX tendon, XX of the XX tendon. The pain level was XX/10 XX pain, numbness XX/10, tingling XX/10, stiffness XX/10, weakness XX/10, popping XX/10, catching XX/10, locking XX/10, located on the XX and XX aspect of the XX, and occurred with activity predominantly during the morning, daytime, evening. The patient was currently working in full capacity. The examination of the XX shoulder revealed XX. The elevation was XX degrees active and XX degrees passive; external rotation was XX degrees passive, external rotation in abduction was XX degrees passive, internal rotation in abduction was XX. The strength was XX XX-/5, XX X/5 and XX XX+/5. There was no tenderness over the XX joint or greater XX. The positive tests included cross body and XX but negative XX, XX and XX XX. Previous x-rays of the XX XX showed normal XX joint (XX), XX, a degenerative XX and normal XX. An MRI of the XX shoulder was reviewed. The diagnoses were sprain of XX XX XX capsule, sprain of the XX XX joint, pain in XX shoulder and preprocedural XX examination. Per exam summary, the XX XX active ROM was good. There was a mild impingement, XX, tenderness at XX and weak elevation. XX recommended XX shoulder arthroscopy, rotator cuff repair and XX (XX).

On XX, a preauthorization request for XX XX arthroscopy, XX XX rotator cuff repair and XX was placed.

Per Utilization Review dated XX, the request for XX XX arthroscopy, XX XX XX XX repair and XX was denied on the basis of following rationale: "*The Official Disability Guidelines, Shoulder Chapter, supports surgery for a full thickness XX XX tear if there is XX pain and inability to elevate the arm as well as weakness on examination and corresponding findings on MRI. This patient complains of XX XX pain and weakness, and there is decreased range of motion of the XX XX on physical examination. The MRI does show a full thickness XX XX tear. However, a XX is only supported if there is tenderness at the XX and temporary relief with an XX injection. This patient does not have XX (XX) joint tenderness, there was a previous steroid injection provided. Furthermore, MRI does not show any XX joint hypertrophy. Accordingly, this request is medically necessary for a rotator cuff repair only. However, as no peer took place, the request remains not medically necessary.*"

On XX, XX was notified about the denial.

On XX, the patient was seen by XX in a follow-up visit. The patient complained of constant stiffness, weakness, popping, catching, and locking in XX XX XX; numbness and tingling radiating to XX XX hand; accompanied by pain that occurred with certain movements. The pain was in the XX, XX aspect of the XX, and occurred with activity predominantly during the morning daytime evening. The examination of the XX XX revealed XX. The elevation was XX degrees active and XX degrees passive; external rotation was XX degrees passive, external rotation in abduction was XX degrees passive, internal rotation in abduction was XX. The XX strength was XX/5, XX XX/5. There was no tenderness over the XX joint or greater tuberosity. The positive tests included XX test and XX test but negative for impingement, XX and Speed tests. The patient was advised to continue full duty with restrictions.

On XX, correspondence by XX indicated the patient initially presented with XX joint tenderness and

the radiographic findings. Based on the patient's failure to improve with conservative management of therapy, injections, NSAID's, persistent moderate to severe current symptoms, XX recommended an experienced shoulder surgeon review the request so to proceed with the recommended treatment.

On XX, an appeal was placed for reconsideration of the request for XX XX arthroscopy, XX XX XX XX repair and XX.

Per Reconsideration dated XX, the denial for XX XX arthroscopy, XX XX XX XX repair and XX was upheld on the basis of following rationale: "*Regarding the request for reconsideration for XX XX arthroscopy, XX XX repair, XX, as outpatient, the patient had failed to improve with muscle relaxers, NSAIDs, and physical therapy. MRI of the XX shoulder did reveal full-thickness XX of the XX tendon with fluid continuing tear into the XX. However, documentation failed to reveal positive tenderness over the XX joint. As such, the request for reconsideration for XX XX arthroscopy, XX XX repair, XX, as outpatient is noncertified.*"

On XX, XX was notified about the denial.

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

The medical rationale documented by the two previous preauthorization review physicians for denial of the XX XX XX appears to have been appropriately formulated.

The denial is UPHELD.

On XX, the XX XX MRI identified no evidence of XX joint abnormality:

XX also documented conflicting findings regarding the XX XX in the "plan" section of the note (positive XX tenderness in the plan section; no tenderness in the exam section):

There is no documentation of a XX XX joint injection.

On XX, XX documented the following examination:

XX did not clarify any issue regarding the XX in the "plan" section of the note:

ODG criteria for DCR are as follows:

XX

The first paragraph discussed treatment for the XX XX tear and provided no evidence that any subjective symptoms or objective clinical exam findings were attributable to the XX XX. There is no documentation that a XX XX injection was ever performed.

The second paragraph states tenderness was documented on the XX note, but as detailed above, the examination and plan sections of the note are conflicting. As far as radiographic findings are concerned, the MRI did not show any evidence of XX, advanced degenerative XX, XX, XX joint instability, or any other finding that is consistent with pathoanatomy that would warrant a DCR. The therapy, injections, and NSAID treatments were directed toward the rotator cuff, not the XX.

Discussion:

The ODG criteria for XX joint resection (XX, or the so-called XX procedure) includes one specific diagnosis and four criteria. (Please note all criteria must be met, connected to each other with the word PLUS.)

The necessary diagnosis is "post-traumatic XX." This claimant does not have any MRI evidence of substantial XX joint XX. THIS DIAGNOSIS IS NOT MET.

Criterion 1: Conservative treatment for 6 weeks. The conservative treatment of the rotator cuff tear is relatively the same for an injured XX joint. THIS CRITERION IS MET.

Criterion 2: Subjective clinical findings: There is no documentation of specific XX joint pain with ROM and weight lifting, and there is no MRI evidence of a Grade I or II separation. THIS CRITERION IS NOT MET.

Criterion 3: Objective clinical findings: Tenderness to palpation (conflicting documentation in the records) AND/OR Pain relief with injection (no evidence of XX joint injection). THIS CRITERION IS NOT MET.

Criterion 4: Imaging findings: Severe post-traumatic XX joint arthrosis or degenerative arthritis OR XX joint separation with a positive bone scan. This claimant does not have any MRI evidence of substantial XX joint XX or acute traumatic separation. THIS CRITERION IS NOT MET.

☐ Medically Necessary

X Not Medically Necessary

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES