

IRO America Inc.

An Independent Review Organization
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DATE OF REVIEW:
AUGUST 27, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1. Right Shoulder Arthroscopy w/Subacromial Decompression w/partial Distal Clavical Resection w/possible Arthroscopic Rotator Cuff Repair
2. Post-Op PCA Pump

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

1. Right Shoulder Arthroscopy w/Subacromial Decompression w/partial Distal Clavical Resection w/possible Arthroscopic Rotator Cuff Repair-APPROVED as medically necessary
2. Post-Op PCA Pump-NOT APPROVED as medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office note, Dr., 02/28/07
Notes, 04/04/07, 04/25/07 and 05/09/07
MRI arthrogram, 04/18/07
Peer review, 05/23/07 and 06/21/07
Reconsideration, 07/11/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a right shoulder injury in a fall from a trailer. X-rays taken in the emergency room were negative for dislocation or fracture. Pain with abduction and overhead activity continued despite over the counter medication and a home exercise program. The claimant continued to work. Clinical exam findings on 02/28/07 noted full motion with positive impingement signs. The impression was right shoulder sprain /strain, residual pain with posttraumatic subacromial bursitis and acromioclavicular joint arthritis. A corticosteroid injection was administered with partial and temporary relief.

MRI arthrogram on 04/18/07 revealed a partial thickness undersurface tear of the infraspinatus tendon, a suspected partial tear of the subscapularis tendon, subacromial subdeltoid bursitis and probable rotator cuff impingement. There were hypertrophic osteoarthritic changes of AC joint and a type III acromion process along with superior labral deterioration but no evidence of a labral tear. A repeat injection on 04/25/07 provided only temporary relief. Arthroscopic subacromial decompression, partial distal clavicle resection and possible rotator cuff repair with a PCA catheter for home pain management was proposed. The request for surgery was non-certified and reconsideration was requested.

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

After a careful review of the medical records, right shoulder arthroscopy with decompression distal clavicle resection and possible arthroscopic cuff repair would appear to be medically necessary. The claimant has symptoms now since he was first treated. He has pain with abduction and overhead activity and a report of a positive impingement sign on examination. This is consistent with the arthritic changes of the acromio-clavicular joint and a Type II hooked acromion. The claimant was reported to have failed treatment with exercises, anti-inflammatory medications and injections. The claimant was noted to have partial relief with an injection which would be a good prognostic factor for surgery. The MRI was consistent with impingement and subacromial bursitis. Based on the failure of conservative measures, the requested surgery would appear to be appropriate and the claimant appears to have met ODG guidelines. The Reviewer therefore would recommend approval of the surgery.

Post-operative PCA pump for home pain management is not generally necessary. It appears the request is for an anesthetic pain pump and the use of such pumps has fallen out of favor. Their efficacy has been questioned in recent studies and toxic effects of local anesthetics have been noted on articular cartilage. Though the pain pump catheter is placed in the subacromial space, there is no guarantee of a water tight seal with the articular space and use of a pain pump would not be recommended.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates , Shoulder Surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery.

ODG Indications for Surgery™ -- Acromioplasty:

Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.)

1. Conservative Care: Recommend 3 to 6 months
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.

Postoperative pain pump- under study, insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures.

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)