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IRO America, Inc.

DATE OF REVIEW: DECEMBER 10, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder arthroscopy

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

No ODG Guidelines
MRI left shoulder 06/05/01
Office note 09/28/07, 10/29/07, 11/26/07
MRI left shoulder 10/19/07
Surgery request 11/07/07
Peer review 11/12/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male injured while lifting a box. An MRI of the left shoulder dated 06/05/001 showed supraspinatus tendinopathy. There were conjoined infraspinatus tendons of the rotator cuff with an intrasubstance tear of the supraspinatus at the

insertion as well as a small amount of subdeltoid and subacromial fluid in the bursa due to bursitis.

On a 09/28/07 office note the claimant reported left shoulder pain progressive since 06/01. On examination there was full strength and motion with positive impingement sign. The provider recommended Ultracet and Skelaxin as well as an MRI. The 10/19/07 MRI of the left shoulder showed an intrasubstance tear of the supraspinatus measuring 1.6 cm. There was some atrophy of the supraspinatus tendon and muscle, a subacromial osteophyte with probable impingement and a Type 1 AC with a normal glenoid. Surgery was recommended but denied twice based on a lack of conservative management. An 11/26/07 office note indicated that the claimant said she had 6 years of conservative treatment that included therapy and all other types of treatment. Surgery was again recommended.

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

Left shoulder arthroscopy does not appear to be medically necessary as the records do not fulfill ODG guidelines. Though the claimant has a reported history of six years of conservative treatment, full conservative care is not documented apart from therapy “and all other types of treatment”. It is not clear that the claimant has been treated with anti-inflammatory medications or a diagnostic and potentially therapeutic anesthetic injection into the subacromial space. The duration of physical therapy also is not recorded. Physical examination data is limited and it is not clear if the patient has a painful active arc of motion from 90 to 130 degrees. Therefore, after a careful review of all medical records, the Reviewer’s medical assessment is that the requested procedure is not medically necessary.

Official Disability Guidelines Treatment in Worker’s Comp 2007 Updates, Shoulder

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: 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.

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)