

MATUTECH, INC.

PO Box 310069
New Braunfels, TX 78131
Phone: 800-929-9078
Fax: 800-570-9544

DATE OF REVIEW: 04 June 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Shoulder arthroscopy and decompression of subacromial space (29826)

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

The physician providing this review is an orthopedic surgeon. The reviewer is national board certified in orthopedic surgery. The reviewer is a member of the American Society for Surgery of the Hand, the American Academy of Orthopedic Surgeons and the Orthopedic Trauma Association. The reviewer has been in active practice for six years.

REVIEW OUTCOME:

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Group:

Office notes (08/07/06 – 01/02/07)
Utilization Reviews (04/17/07 & 05/10/07)
Attorney's Letter (04/12/07)

Institute:

Office notes (01/16/02 – 02/01/07)
Diagnostic studies (02/17/03 – 04/12/06)
Procedure notes (09/29/03 – 06/30/06)
Therapy notes (10/28/03 – 03/12/07)
Reviews, RME (10/14/02 – 08/03/06)

PATIENT CLINICAL HISTORY:

The patient is a male who had a work-related injury on xx/xx/xx, while working as an installer fitter for. He was trying to pull out a threading machine and the handle slipped. He was hit on his head and on the right shoulder. He sustained a traction-type injury to his right shoulder and neck.

Initially, the patient received physical therapy (PT) and a steroid injection into his right shoulder, which provided temporary relief. Magnetic resonance imaging (MRI) of the right shoulder showed mild thickening of the distal portion suggesting chronic tendinitis. A history of knee and hand surgeries was noted. In February 2003, M.D., an orthopedic surgeon, obtained x-rays of the right shoulder, which showed obvious degenerative changes of the acromioclavicular (AC) joint. MR arthrogram of the right shoulder was consistent with tendinitis of the supraspinatus tendon as well as subacromial/subdeltoid bursitis, inflammatory changes of AC joint and degenerative changes involving the anterior/superior labrum. Electrodiagnostic studies were indicative of a chronic, severe right carpal tunnel syndrome (CTS) and probable chronic progressive right C5-C6 right foraminal narrowing. Dr. administered a subacromial steroid injection into the right shoulder and referred the patient for the cervical evaluation to, M.D. MRI of the cervical spine revealed spondylosis with degenerative disease at C5-C6 and C6-C7 with annular bulges from C3 through C7, largest at C4-C5 and C6-C7. X-rays revealed hypermobility of the C3 segment. Dr. felt that the patient was not a good candidate for cervical surgery due to the three-level degeneration.

On September 29, 2003, Dr. performed right shoulder arthroscopic acromioplasty, coracoacromial ligament release, and excision of the distal clavicle and acromioclavicular (AC) joint. Postoperatively, the patient was placed into rehabilitation. In November 2003, M.D., performed a required medical evaluation (RME). He opined that cervical spondylosis was a degenerative change of ordinary life; however, mild cervical radiculopathy and referred pain was related to the shoulder injury. The patient was treated with cervical epidural steroid injections (ESI)/selective nerve root blocks x3, which provided 50% pain relief. A CT-myelogram revealed narrowing of the neural foramen on the right at C4-C5 possibly comprising the exiting nerve root, mild mass effect on the right aspect of the cord at C5-C6 due to central posterior osteophyte, and right posterior paramedian disc herniation.

On September 7, 2005, Dr. performed anterior cervical discectomy, and fusion (ACDF) and decompression from C4 through C7. M.D., a designated doctor, assessed statutory MMI as of January 30, 2005, and assigned 15% whole person impairment (WPI) rating. In December 2005, the treatment was again focused towards the right shoulder for persistent symptoms. Dr. obtained MRA of the shoulder, which showed degenerative changes within the tendon and questionable labral changes. MRI of the cervical spine showed borderline-to-

mild broad-based C3-C4 disc protrusion and postoperative changes from C4 through C7. Dr. injected a steroid preparation into the right subacromial joint on two occasions and felt that the patient might need right shoulder surgery. In 2006, the patient was treated with a trigger point injection (TPI) and a right occipital nerve block for persistent cervical postlaminectomy syndrome, right occipital neuralgia, and severe myofascial pain. In October 2006, the patient was placed into rehabilitation for four weeks. M.D., while providing a second opinion, reviewed the MR arthrogram performed in April 2006, and interpreted a full-thickness supraspinatus tear in the anterior portion and type II SLAP lesion. He recommended arthroscopic subacromial decompression, rotator cuff repair, and biceps tenodesis.

In January 2007, Dr. obtained MRI of the cervical spine, which showed residual foraminal narrowing at C5-C6 and C6-C7 and mild disc bulging at C3-C4. The patient was placed into therapy, which lasted through March, for a total of 12 sessions.

On April 17, 2007, a request for right shoulder surgery was denied for the following reason: Dr. noted that the patient had multiple complaints at the neck and other areas, but his shoulder was symptomatic and no physical examination was provided. Surgery was briefly discussed. The patient had long-standing right shoulder pain and surgical history was unknown at that point. These records did not contain any specific clinical information regarding the current right shoulder complaints, physical examination with objective findings, imaging studies to document surgical lesion, or conservative treatments provided to date relative to the right shoulder

On May 10, 2007, a reconsideration request for the right shoulder surgery was denied with following rationale: There was no documentation in the records provided regarding positive provocative testing such as Neer or Hawkins' testing. It would also appear that the patient has not been treated conservatively with nonsteroidal anti-inflammatory drugs (NSAID) and therapy, and there was no indication that he has received a cortisone injection, which could be both diagnostic and therapeutic. Additionally, no imaging studies including x-rays and MRI films showing the presence of a tear versus other shoulder pathology is available.

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

After review of the medical records provided, it is this reviewer's opinion that insufficient documentation in support of the proposed procedure (Shoulder arthroscopy and decompression of subacromial space) has been provided. No methodology has been applied and/or documented in the record to help rule out instability as the cause of Mr. impingement symptoms (e.g. No crank or

apprehension/relocation tests). No effort has been made and/or documented to treat the shoulder symptoms conservatively (i.e. with shoulder girdle strengthening and scapular stabilization exercises). Also, much has been made of the "subtle rotator cuff tear" seen on MRI; however, there is a 30% incidence of asymptomatic cuff tears in the general population over the age of 60, so merely the presence of a subtle cuff tear does not justify a surgical indication. These issues could be resolved with a complete physical exam and period of rotator cuff strengthening with Thera bands at home. If that were appropriately documented then surgical treatment might be justifiable. However, given the documentation provided and the absence of these basic descriptions, this reviewer agrees at this time with the denial.

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

The guidelines utilized in arriving at recommendations for this case are based on well established standards recognized within the orthopedic community and supported by professional literature, training standards and experience. Additional referencing is taken from the National Guidelines Clearinghouse at www.guidelines.gov.