

IRO Express Inc.

An Independent Review Organization

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IRO REVIEWER REPORT TEMPLATE -WC

DATE OF REVIEW:

JUNE 11, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Rt RCR, bicep tenodesia AC resection, acromioplasty

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Right shoulder MRI without contrast, 02/21/07

Office notes, Dr. 04/02/07, 04/16/07

Peer review, Dr. 04/25/07

Appeal letter, Dr. 05/04/07

Chart note, Dr. 05/11/07

Peer review, Dr. 05/14/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This female injured her right shoulder on xx/xx/xx when she was pushing a barrel in a parking lot. She underwent right shoulder rotator cuff repair on 02/21/05 and rotator cuff repair for a recurrent tear on 03/16/06. The MRI of the right shoulder on 02/21/07 demonstrated a tear of the distal portion of the supraspinatus along the insertion of the humeral head with evidence of previous surgery of the humeral head. There was minimal prominence of the acromio-clavicular joint type I, mild atrophy of the supraspinatus and a small amount of subacromial bursitis.

Dr. evaluated the claimant on 04/02/07 and described persistent problems after surgery with pain at the greater tuberosity and acromio-clavicular joint. The claimant had extensive physical therapy. On exam she had positive Neer and Hawkins tests and positive cross body test. Resisted abduction was painful. Forward flexion was to 145 degrees with 90 degrees of abduction and 80 degrees of external rotation. The diagnosis was subacromial bursitis, degenerative joint disease of the acromio-clavicular joint and full thickness tear of the rotator cuff. A subacromial injection was given. As of 04/16/07, the claimant had minimal pain relief with the injection. She had tenderness of the acromio-clavicular joint and bicipital groove, positive Neer and Hawkins tests and painful resisted abduction. The physician recommended distal clavicle resection, subacromial decompression, rotator cuff repair, possible allograft patch and biceps tenodesis. Surgery was denied on peer review.

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

Outpatient shoulder surgery for rotator cuff repair revision for the second time biceps tenodesis acromio-clavicular joint resection and acromioplasty does not appear to be medically reasonable at this present time. Review of 02/21/07 MRI of the right shoulder with contrast demonstrates a tear at the distal portion of the supraspinatus tendon. This is a post-surgical MRI which is much more difficult and complex to interpret. There is no evidence of demonstrable weakness of the rotator cuff. There is only a positive Neer and Hawkin's impingement signs and only pain with resisted abduction. However, there is no quantification of the strength. There is no documentation of the claimant's response to an injection of the subacromial space. Without documentation of the response following an injection of the subacromial space which likely will infiltrate the acromioclavicular joint and provide some relief from acromioclavicular joint arthrosis, the reason to go back and revise the shoulder is unclear. In addition, intra-articular injection can be both diagnostic and beneficial in treating bicipital tendinopathy which can be another source of etiology for the claimant's symptoms. In essence without exhaustive conservative measures, the reviewer does not think revision surgery is necessary at this present time given that this patient has already had in 2005 and 2006 rotator cuff repair surgery and in spite of that is complaining of persistent pain and dysfunction. Until a more exact diagnosis has been delineated and all conservative care has been exhausted such as anti-inflammatories in the instance of acromioclavicular joint arthroses and an intra articular injection, at least diagnostically for bicipital tendinopathy in consideration for an injection of corticosteroid additional surgery cannot be warranted.

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

Surgery for impingement syndrome:

Recommended as indicated below. 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. Since this diagnosis is on a continuum with other rotator cuff conditions, including rotator cuff syndrome and rotator cuff tendonitis, see also Surgery for rotator cuff repair. (Prochazka, 2001) (Ejnisman-Cochrane, 2004) (Grant, 2004) Arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff. (Gartsman, 2004) This systematic review comparing arthroscopic versus open acromioplasty, using data from four Level I and one Level II randomized controlled trials, could not find appreciable differences between arthroscopic and open surgery, in all measures, including pain, UCLA shoulder scores, range of motion, strength, the time required to perform surgery, and return to work. (Barfield, 2007)

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.

(Washington, 2002)

Surgery for rotator cuff repair:

Recommended as indicated below. Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, but the outcomes from open repair are as good or better. Surgery is not indicated for patients with mild symptoms or those who have no limitations of activities. (Ejnisman-Cochrane, 2004) (Grant, 2004) Lesions of the rotator cuff are best thought of as a continuum, from mild inflammation and degeneration to full avulsions. Studies of normal subjects document the universal presence of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment but without surgical risks. Studies evaluating results of conservative treatment of full-thickness rotator cuff tears have shown an 82-86% success rate for patients presenting within three months of injury. The efficacy of arthroscopic decompression for full-thickness tears depends on the size of the tear; one study reported satisfactory results in 90% of patients with small tears. A

prior study by the same group reported satisfactory results in 86% of patients who underwent open repair for larger tears. Surgical outcomes are much better in younger patients with a rotator cuff tear, than in older patients, who may be suffering from degenerative changes in the rotator cuff. Referral for surgical consultation may be indicated for patients who have: Activity limitation for more than three months, plus existence of a surgical lesion; Failure of exercise programs to increase range of motion and strength of the musculature around the shoulder, plus existence of a surgical lesion; Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair; Red flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.). Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears are treated the same as impingement syndrome regardless of MRI findings. Outpatient rotator cuff repair is a well accepted and cost effective procedure. (Cordasco, 2000) Difference between surgery & exercise was not significant. (Brox, 1999) There is significant variation in surgical decision-making and a lack of clinical agreement among orthopaedic surgeons about rotator cuff surgery. (Dunn, 2005)

ODG Indications for Surgery™ -- Rotator cuff repair:

Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND cervical pathology and frozen shoulder syndrome have been ruled out:

1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS
2. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS
3. Imaging Clinical Findings: Conventional x-rays, AP and true lateral or axillary views. AND Gadolinium MRI, ultrasound or arthrogram shows positive evidence of deficit in rotator cuff.

Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR 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.

(Washington, 2002)

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)