



DATE OF REVIEW: 11/6/07

AMENDED DATE: 12/4/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical necessity for subacromial decompression with debridement of the right shoulder.

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

Texas Licensed 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)

The previously denied request for

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Notice to CompPartners, Inc. of Case Assignment dated 10/26/07.
- Confirmation of Receipt of a Request for a Review dated 10/25/07.
- Request for a Review by Independent Review dated 10/23/07.
- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 10/26/07.
- Interim Report/Pre-Authorization Request dated 9/7/07.
- Patient Information Record dated 9/21/07.
- History of Present Illness dated 9/21/07, 8/24/07.
- Right Shoulder MRI dated 6/15/07.
- Initial Examination /Evaluation Report dated 6/6/07.
- OSOA Workers Compensation Verification (unspecified date).
- Reconsideration of Medical Determination dated 10/19/07.
- Notification of Determination dated 10/5/07.
- Fax Cover Sheet IRO Number 10295 dated 10/26/07.
- Fax Cover Sheet Appeal dated 10/12/07.
- Fax Cover Sheet Authorization Request dated 10/2/07.
- Fax Cover Sheet Pre-Authorization Request dated 9/10/07.

No ODG were provided by the URA for this referral.

PATIENT CLINICAL HISTORY [SUMMARY]:

Age: xx
Gender: Female
Date of Injury: xx/xx/xx
Mechanism of Injury: The patient fell in a laundry room, hitting her right shoulder on a dryer door.

Diagnosis: Status post rotator cuff tear in April 2007, and adhesive capsulitis.

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

The patient is a female with a date of injury of xx/xx/xx. The mechanism of injury was the patient fell in a laundry room, hitting her right shoulder on a dryer door. The diagnosis is status post rotator cuff tear in xx/xx/xx and adhesive capsulitis. She was originally treated for rotator cuff tear with surgical intervention in xx/xx/xx where a rotator cuff repair was performed. That operative report was not available for review. The patient was seen on June 6, 2007 by Dr., and was noted to have had constant pain complaints in the right shoulder. The physical examination of the right shoulder revealed flexion of 80 degrees with sharp pain at the shoulder, extension 10 degrees, external rotation 10 degrees, internal rotation 10 degrees, abduction 15 degrees, adduction 10 degrees. The treatment plan at that time was the patient to stay off work and have an MRI performed. The MRI was performed on June 15, 2007, which revealed the post surgical findings, but no evidence of a new tear retraction of the musculotendinous junction. It did note a possible normal variant Buford complex of the anterior labrum and capsulitis of the acromioclavicular (AC) joint, with arthrosis with slight compression on the musculotendinous junction with supraspinatus muscle. The patient was then seen on August 24, 2007 by Dr. in a follow-up that noted complaints of right shoulder pain with the examination. There was no noted atrophy. Range of motion was 90 degrees, 20 degrees, and 10 degrees, but no definition of which motion the quantifications were for. There was positive Neer's, positive Hawkins', positive O'Brien's, and negative cross-arm. Strength was 5/5 for all muscle groups tested, and no focal neurological deficits were noted. The diagnosis was adhesive capsulitis of the shoulder and subacromial bursitis. The patient was referred for physical therapy protocol two to three times a week for four weeks for frozen shoulder, and activities were restricted as dictated by her symptoms. The patient was advised with home exercises in conjunction with the physical therapy. On September 7, 2007 at the Clinic, the patient was requested to receive 12 sessions of physical therapy. Again, range of motion noted 60 degrees of flexion, 10 degrees for extension, and external rotation and internal rotation with abduction 15 degrees and adduction 10 degrees all of which were decreased. Then on September 21, 2007, Dr. reevaluated the patient, noting that nonsteroidal anti-inflammatory drugs (NSAIDs) partially improved the symptoms, physical therapy partially improved the symptoms, and surgery partially improved the symptoms, and he noted that there was no improvement after injection and physical therapy. The physical findings noted active

range of motion 100 degrees, 30 degrees, 40 degrees, and again the motions were not indicated for which range. The patient still had positive Hawkins', Neer's, and positive O'Brien's test. There was no change in muscle strength. The rationale for a non-certification of the requested therapy is the patient records only indicated treatment having started on August 24, 2007, when Dr. provided an injection to the shoulder and ordered physical therapy. The Official Disability Guidelines criteria noted at least "three to six months of conservative treatment" be carried out prior to a consideration for surgery, and the medical records at this time did not indicate that the criteria was satisfied. With the medical records provided for review, the requested surgical intervention is not supported as being medically necessary at this time. This reviewer feels this is in line with Official Disability Guidelines.

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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Official Disability Guidelines, Treatment Index, 5th Edition, 2006/2007
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 Arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff.

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.

Official Disability Guidelines, Treatment Index, 5th Edition, 2006/2007

Shoulder-surgery for Adhesive Capsulitis

Under study. The clinical course of this condition is considered self-limiting, and conservative treatment (physical therapy and NSAIDs) is a good long-term treatment regimen for adhesive capsulitis, but there is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment. Study results support the use of physical therapy and injections for patients with adhesive capsulitis.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.
