

P-IRO Inc.

An Independent Review Organization
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DATE OF REVIEW: SEPTEMBER 23, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder arthroscopy subacromial decompression and CAL distal clavicle, subacromial decompression and CAL release, LFT. Shoulder instrin implant biodegradable, LFT. Shoulder brachial plexus.

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

MRI left shoulder 09/13/05
EMG/NCV 10/13/06
MRI left shoulder 05/29/07
Office note of Dr. 07/16/07
Peer review 07/26/07
Letter from Dr., undated
Peer review 08/29/07
No ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This male was injured when he was involved in a motor vehicle accident. He underwent left shoulder surgery on 03/31/06, apparently without significant improvement. A

10/13/06 EMG/NCS demonstrated right C6 radiculopathy. An MRI of the left shoulder was done on 05/29/07 that demonstrated evidence of moderate strain/tendonitis involving the periphery of the supraspinatus tendon. There was some subtle fraying and irregularity involving the superficial anterior peripheral tendon fibers. No full thickness tear or retraction was seen. The claimant was evaluated on 07/16/07 by Dr. with severe constant left shoulder pain. Left shoulder range of motion was normal. Supraspinatus strength was 4/5; infraspinatus and subscapularis strength was 4+/5. X-ray of the left shoulder was normal. The diagnosis was impingement. Dr. administered an acromio-clavicular joint injection on 07/16/07 that alleviated most of his pain. Dr. recommended left shoulder arthroscopy, subacromial decompression, coracoacromial ligament release, distal clavicle excision and evaluation of the rotator cuff. The surgery was denied on peer review.

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

The injury occurred over two years ago. Records indicate that the claimant treated for cervical and left shoulder pain. He subsequently underwent left shoulder surgery in March 2006 but the operative report is not provided and there is no specific information on the surgical procedure or intraoperative findings. No clinical information is provided regarding the claimant's postoperative course. Electrodiagnostic studies were done in October 2006 that document right C6 radiculopathy. No further records are provided until a left shoulder MRI in May 2007. No physician notes are provided until Dr.'s evaluation in July 2007 on this 2005 injury. The claimant has normal range of motion and mild rotator cuff weakness. An impingement test was positive. The claimant may well have indications for additional surgery but based upon the medical records there is insufficient information provided to make that determination.

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)

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)**