

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 27, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder arthroscopy, acromioplasty, rotator cuff repair, distal clavicle resection, labral debridement repair.

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

M.D., 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.

The reviewer finds that medical necessity does not exist for left shoulder arthroscopy, acromioplasty, rotator cuff repair, distal clavicle resection, labral debridement repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 04/14/08, 04/25/08

Official Disability Guidelines

Office notes, Dr. 10/01/07, 10/03/07, 10/17/07, 10/30/07, 12/20/07, 01/16/08

Office notes, Dr. 12/12/07, 02/06/08, 02/20/08, 04/02/0

Physical therapy records, 10/01/07, 10/03/07

MRI left shoulder, 10/23/07

MRI cervical spine, 01/07/08

Surgery pre- authorization request, 04/08/08
Letter from attorney, 05/20/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This male claimant reportedly had a left shoulder injury after unloading an electrical transformer. The records indicated that the claimant was initially evaluated and diagnosed with a left shoulder strain and was treated conservatively with medication, physical therapy and activity modification.

The left shoulder pain persisted along with numbness and weakness in the left fourth and fifth fingers. An MRI of the left shoulder performed on 10/23/07 revealed tendinosis, bursitis and type II acromion. A subacromial injection followed on 12/12/07 which reportedly gave no relief. A cervical spine MRI on 01/07/08 showed mild degenerative changes. A second injection was performed again with no reported benefit.

The claimant continued to have left shoulder pain with positive examination finding despite conservative care. Surgery in the form of a left shoulder arthroscopic acromioplasty, distal clavicle resection, rotator cuff debridement and labral debridement was recommended.

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

The requested surgery for left shoulder arthroscopy, acromioplasty, rotator cuff repair, distal clavicle resection, labral debridement repair cannot be recommended as medically necessary based on the information reviewed.

ODG guidelines for impingement surgery require at least temporary relief of pain with an anesthetic injection in the subacromial space. This claimant has failed two prior shoulder injections without reports of benefit. The claimant's acromioclavicular tenderness and pain with cross chest adduction has been variable upon multiple evaluations. The claimant has confounding factors of numbness in the extremity that would be unrelated to the shoulder. The MRI does not clearly indicate a full thickness rotator cuff tear. The failure to respond at least temporarily to an injection, variable physical examination findings, and confounding factors make this claimant a poor surgical candidate and he does not fulfill the ODG criteria for the surgical procedure being proposed.

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

Surgery for impingement syndrome

Surgery for rotator cuff repair

Surgery for impingement syndrome

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.

Surgery for rotator cuff repair

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.

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)