I-Decisions Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 2, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient left shoulder arthroscopy with debridement, lysis of adhesions, open claviculectomy and open rotator cuff 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 outpatient left shoulder arthroscopy with debridement, lysis of adhesions, open claviculectomy and open rotator cuff repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 12/30/08, 01/08/09
ODG Guidelines and Treatment Guidelines
Office notes, Dr. 07/31/07, 08/21/07, 09/13/07, 11/08/07, 12/07/07, 01/18/08, 04/04/08, 05/16/08, 07/31/08, 10/24/08, 12/02/08
X-rays left shoulder, 07/31/07, 12/07/07, 01/02/08
Physical therapy plan of care, 08/07/07, 11/20/07

Note, Dr. 09/25/07
Operative report, 10/24/07
Physical therapy progress report, 01/07/08
Record Review, Dr. 07/14/08
X-rays left clavicle, 08/01/08
X-rays shoulder, 10/24/08
Review, Dr. 11/10/08, 12/03/08
MRI left shoulder, 11/18/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a left hand dominant female who felt a pop in her left shoulder on xx/xx/xx while lifting a box that weighed about 50 pounds. She was found to have impingement syndrome, an acromioclavicular sprain and a possible rotator cuff tear. On 10/24/07 she underwent a left shoulder arthroscopic subacromial decompression and SLAP debridement with debridement of anterior synovitis and a distal clavicle excision.

Dr. saw the claimant on 11/08/07 complaining of pain at the site of the distal clavicle excision. Left shoulder active/passive motion was: forward flexion 120/140 degrees, abduction 120/130 degrees, external rotation 45/45 degrees, and extension 30/30 degrees. She had positive cross arm, Hawkins and impingement signs. She was to advance her home exercise program, start formal therapy and continue light duty with no lifting of the left arm. Naprosyn was refilled. At the 12/07/07 followup visit she reported popping and pain over the site of the acromioclavicular resection with therapy and difficulty sleeping. There was pain with abduction and forward flexion. Cross arm, Hawkins, impingement and Speed's were positive. X-rays showed a good decompression of the acromioclavicular joint and popping that could be synovitis. Continuation of therapy was recommended. The shoulder was injected and Vicodin prescribed.

Dr. saw the claimant on 01/02/08 and she had been doing well post injection. However while in therapy on 12/31/07 she felt a pop across her left shoulder and now had 2 days of superior pain. There was tenderness over the site of the acromioclavicular resection. Forward flexion was to 140 degrees and abduction to 120 degrees. X-rays showed no change of position of the clavicle and no bony abnormalities. Dr. felt that she had broke up scar tissue and recommended a dose pak, Relafen, Lortab, a Lidocaine patch and continuation of light duty and her home exercise program. Left shoulder x-rays on 01/02/08 showed stable operative changes of the left subacromial decompression surgery.

At the 04/04/08 visit she reported being unable to reach behind to fasten her bra, but was doing better than preoperatively. Most of her discomfort was superior after working a full week. There was tenderness at the acromioclavicular joint, pain with forward flexion and positive Hawkins and impingement signs. Active/passive motion was: forward flexion 150/160 degrees, abduction 140/150 degrees, external rotation 90/90 degrees, internal rotation T10/T10 and extension 20/30 degrees. The shoulder was injected. The claimant was seen again on 05/16/08 reporting she had been working 3, 12 hour shifts and at the end of the 3rd shift had posterior shoulder pain. She stated that a TENS unit and Lidoderm patches had helped. There was tenderness of the posterior and superior shoulder, increased pain with abduction and external rotation, functional shoulder motion and negative provocative studies. A trigger point injection was given into the posterior shoulder. She was felt to be at Maximum Medical Improvement and it was recommended that she continue full activities and have an impairment rating. Dr. reviewed the records on 07/14/08 and opined that no further formal evaluation or

management appeared medically reasonable and necessary to treat the injury to the biceps anchor and anterior labrum.

Dr. re-evaluated the claimant on 07/31/08 with more shoulder pain and pain with trying to raise the arm. She reported that the last injection helped. Working 5, 12 hour shifts was aggravating her shoulder. She had more pain over the site of the acromioclavicular resection than the posterior and hurt with overhead activity. Tenderness of the acromioclavicular joint and increased pain with forward flexion were noted on examination. Active/passive motion was: forward flexion and abduction 140/150 degrees, external rotation 100/100 degrees, internal rotation T10/T10, and extension 30/30 degrees. Cross arm, Hawkins and impingement signs were positive. X-rays of the left shoulder showed a good resection of the acromioclavicular joint and no calcification of the space. Inflammation of the acromioclavicular resection was diagnosed. Relafen was prescribed and a cortisone injection given. X-rays of the left clavicle on 08/01/08 demonstrated a well-healed surgical site and post resection of the distal clavicle. The claimant was seen again on 10/24/08 and stated that the last injection helped for about a month to a month and a half and relieved 70 percent of her symptoms, but had started to return. She was taking a Lidoderm patch, Naprosyn and Nabumetone. She complained of pain across the top of her shoulder with occasional popping or clicking and pain with overhead activities and reaching across her body. Left shoulder x-rays that day showed possible calcification of the soft tissue at the site of the acromioclavicular resection, a good resection, but possible calcium reforming which could be the source of her recurrent pain into that shoulder. She had not responded to injections, Lidoderm patches, anti-inflammatories or therapy. Strength was 4/5 for the deltoid, there was decreased C8 sensation, tenderness at the acromioclavicular joint and increased pain with cross arm adduction. Active/passive motion was forward flexion 100/140 degrees, abduction 90/120 degrees, external rotation 90/90 degrees, internal rotation L2/L2 and extension 40/50 degrees. Cross arm, Hawkins, impingement and O'Brien's were positive. Dr. recommended an open exploration of the distal clavicle resection site and debridement of any scar tissue and synovitis. He also discussed a scope to look at the rotator cuff, subacromial space and labral region at time of open debridement. The x-ray report from that day showed a normal postoperative appearance. Dr. re-reviewed the case on 11/10/08 and noted her continued acromioclavicular symptoms that may need to be further evaluated by surgical evaluation. He stated that the etiology of her symptoms may not be clear at the time of surgical exploration and if that was the case the outcome may be less favorable.

A left shoulder MRI on 11/18/08 showed interval acromioclavicular joint surgery, but otherwise a similar appearance of the shoulder. The distal supraspinatus tendon demonstrated hypertrophic tendinopathy without a full thickness defect or tendon retraction. There was a small medial subchondral humeral head fibrocystic focus that had not changed. The posterior labrum contained a newly demonstrated small focal tear of focus myxomatous degeneration. Dr. saw the claimant again on 12/02/08 with ongoing left shoulder pain laterally and superiorly, popping and clicking with pain reaching across her body and overhead. X-rays reportedly showed recalcification along the site of the acromioclavicular resection. She had 4/5 left deltoid strength, tenderness of the greater tuberosity and acromioclavicular joint and worse pain with abduction and external rotation. Active/passive motion was: forward flexion 140/140 degrees, abduction 130/140 degrees, external rotation 90/100 degrees, internal rotation T10/T10 and extension 40/40 degrees. Cross arm, Hawkins, impingement and O'Brien's were positive. Worse bursitis of the shoulder was diagnosed. Dr. recommended excision of the acromioclavicular resection site, evaluation of the rotator cuff, possible rotator cuff repair and debridement and evaluation of the labrum arthroscopically.

On 12/03/08 Dr. again reviewed the case and opined that there was no specific finding on the most recent MRI that would unequivocally establish the need for surgery. However, he found the need for surgical exploration of the acromioclavicular joint may be necessary, particularly if there has been under-resection or asymmetric resection of the distal clavicle. He stated that either scenario may be a functional issue and may not be apparent on imaging studies and that either situation may be successfully addressed with improved distal clavicle resection. He stated that if these 2 situations are not present, the persistent acromioclavicular joint pain may be due to disruption of the acromioclavicular joint capsuloligamentous restraints. He also stated that this will not likely have a good outcome, no matter what procedure is done.

The proposed surgery was denied on two prior reviews 12/30/08 and 01/08/09 and is currently under dispute.

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

This female underwent prior left shoulder surgery. This consisted of a left shoulder arthroscopic subacromial decompression, labral debridement, debridement of anterior synovitis, and distal clavicle excision on 10/24/07. She has had persistent complaints of pain. The etiology of such is not adequately explained. Dr. has treated her extensively. The rationale for further surgery was poorly outlined. Her current subjective complaints appear to out weigh her physical findings. Dr. reviewed the case once again, 12/03/08, and felt that there were no specific findings on the most recent MRI that could establish the requirement for surgery. He, however, felt that surgical exploration of the acromioclavicular joint may be necessary, particularly if there had been under resection or asymmetric resection of the acromioclavicular joint. He stated that he felt that the claimant would not likely have a good outcome no matter what procedure was done. The rationale for further surgery is poorly outlined in the clinical information. This reviewer would not recommend repeat surgery based on the Official Disability Guidelines. The records do not reflect any documented rotator cuff tear on the diagnostic studies. The claimant has ongoing complaints of pain despite prior surgery. The most recent MRI of 11/18/08 showed an interval acromioclavicular joint surgery. There was evidence of tendinopathy, but no evidence of a full thickness tear. Thus, the rationale for further surgery was not adequately outlined in the information reviewed. The reviewer finds that medical necessity does not exist for outpatient left shoulder arthroscopy with debridement, lysis of adhesions, open claviculectomy and open rotator cuff repair.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates, (i.e. Shoulder – Surgery for Rotator Cuff Tear, Diagnostic Arthroscopy)
Recommended as indicated below. Criteria for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear.

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) For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopaedic referral. Patients with small tears of the rotator cuff may be referred to an orthopaedist after 6 to 12 weeks of conservative treatment. (Burbank2, 2008) Patients with workers' compensation claims have worse outcomes after rotator cuff repair. (Henn, 2008)

Revision rotator cuff repair: The results of revision rotator cuff repair are inferior to those of primary repair. While pain relief may be achieved in most patients, selection criteria should include patients with an intact deltoid origin, good-quality rotator cuff tissue, preoperative elevation above the horizontal, and only one prior procedure. (Djurasovic, 2001)

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)**