

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

Notice of Independent Review Decision

DATE OF REVIEW: 7/20/09

IRO CASE #:

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

This case was reviewed by a Orthopaedic Surgery, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthroscopic subacromial decompression right shoulder; arthroscopic distal clavicle resection right shoulder; arthroscopic rotator cuff repair right shoulder

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o Treatment guidelines were not provided to the IRO.
- o List of records (date, who from, description)
- o xx/xx/xx Doctor's First report of injury, unsigned
- o xx/xx/xx Initial Narrative report from Dr.
- o 02-15-09 DWC Form 73 from Dr.
- o 02-19-09 Patient referral form, referral for MRI, unsigned
- o 02-11-09 Fax note from Radiology
- o 02-25-09 MRI right shoulder read by Dr.
- o 03-19-09 Patient information sheet from Orthopedic
- o 03-20-09 DWC Form 73, orthopedic consultation report and PT referral, from Dr.
- o 03-27-09 Peer Review Summary - cited but not included in medical records
- o 03-31-09 Patient information sheet from Dr.
- o 03-31-09 Physical Therapy evaluation form
- o 00-00-00 Undated and unsigned retrospective review
- o 04-06-09 PT outpatient daily notes 4-6-09 through 4-30-09
- o 04-06-09 Peer Review from Dr.
- o 04-07-09 Notice of Disputed Issues
- o 04-16-09 DWC Form 73 from Dr.
- o 04-17-09 Medical report from Dr.
- o 04-17-09 PT referral form with instructions from Dr.
- o 05-08-09 DWC Form 73 and medical report from Dr.

- o 05-11-09 Surgery order from Dr.
- o 05-13-09 Pre-cert from Dr.
- o 05-18-09 Utilization review outcome letter
- o 06-09-09 Letter from Dr. with rationale for surgery
- o 06-16-09 Utilization review outcome letter for reconsideration
- o 07-10-09 Medical report and rationale for surgery from Dr.
- o 07-17-09 IRO Summary from Claims Management

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records submitted for review, the patient is a female who presented for evaluation and treatment on xx/xx/xx, 2009 for right shoulder complaints associated with an incident of xx/xx/xx. The patient reported lifting a 20-pound box onto a shelf when she felt shoulder pain. She did not report a click or a pop. She has been having pain at night. There is tenderness at the right neck and anterior aspect of the shoulder. Flexion is to 90 degrees with pain. Abduction is to 120 degrees with pain. Cervical x-rays show degenerative changes. Shoulder x-rays are negative. The patient is provided a diagnosis of right shoulder and upper arm sprain. Request is made for MRI.

Right shoulder MRI was performed on February 25, 2009 and provided impression: Small but deep bursal sided partial thickness tear of the supraspinatus tendon. Interstitial partial thickness tear of the subscapularis tendon. Subscapularis, supraspinatus, infraspinatus tendinopathy. Subchondral glenoid cyst probably associated with a small focus of chondromalacia. Mild subacromial spurting and mild acromioclavicular joint osteoarthritis. Mild subacromial -subdeltoid bursitis.

According to an IRO summary of July 17, 2009 the patient underwent arthrocentesis aspiration on March 20, 2009, apparently for the subchondral glenoid cyst.

The patient was examined orthopedically on March 19, 2009. The patient is 5' 3" and 200 pounds. She describes the injury as "hurt right shoulder." The patient reports numbness and tingling, radiating pain, swelling, limited motion and difficulty sleeping. She is using Premiren, Hydrocodone, Celexa, Skelaxen and Naproxen.

The orthopedic consultation report of March 20, 2009 states the patient reported a pop in her shoulder when putting a box on a shelf. She reports the pain is all over her shoulder and increases with certain movements. She complains of painless popping of the shoulder. Forward flexion is to 180 degrees and abduction to 160 degrees. Hawkins in mildly positive. There is mild to moderate tenderness at the AC and SC joint and over the anterior and posterior shoulder. Strength is 5/5. O'Briens is negative. X-rays taken this visit show mild AC joint degenerative changes. Impression is rotator cuff tear, partial. Shoulder joint pain and rotator cuff tendonitis (syndrome). Recommendation is for a cortisone injection. Vicodin is prescribed but she needs to wean this medication. PT of 6-8 weeks is ordered.

The patient was assessed in PT on March 31, 2009. She is still working but not lifting anything heavy. Six visits have been authorized. She has functional active range of motion but pain at end range of motion. She reports a pain level of 7/10 at rest. Strength is 4- to 4+ with major motions.

At the PT visit of April 6, 2009 the patient reported increased pain after treatment. Joint mobilization maneuvers were planned. PT notes of April 14, 2009 indicate the patient is dissatisfied with therapy. She states her pain is greater than prior to therapy. She has not been doing her HEP as she was not given the exercise sheets. She states "this physical therapy is worthless" and will not help two tears in the shoulder. She states the employer is trying to only pay for the initial sprain. She was advised to consult with her doctor and be pro-active. On April 30, the patient reports to the therapist, no relief with her shoulder pain. Per the patient, she is unable to hold a cup of coffee or scrub her bathtub. She is unable to tolerate the strengthening exercises. She reports pain of 5/10 at rest and increase of pain with movement.

A Peer Review was provided on April 6, 2009. There were conflicting reports as to whether the claimant heard or felt a pop at the time of the work event. MRI shows pre-existing findings including cysts, AC joint osteoarthritis, mild bursitis and moderate tendinopathy. The partial tear seen on imaging is likely a degenerative tear versus an acute rotator cuff tear. According to the literature significant evidence exist to support intrinsic degeneration as an important cause of partial thickness rotator cuff tears. The evidence is strongly linked with advancing age. The actual physical damage from the incident at work would be a right shoulder strain or temporary exacerbation of pre-existing disease of life findings with no acute structural damage of the right shoulder in all probability. The patient can be anticipated to realize a complete recovery in the next 6 weeks. A repeat subacromial injection would be reasonable. An over-the-counter anti-inflammatory would be reasonable. She should be able to return to work pre-injury status in the next 6 weeks.

A Notice of Disputed Issues was issued on April 7, 2009 from the carrier. The carrier indicates that they are accepting the right shoulder sprain/strain only and not the pre-existing conditions visualized on imaging.

The patient was reevaluated orthopedically on April 17, 2009. She reports an increase in pain over the past few weeks. She has been doing a lot of activities at work, which could be exacerbating her condition. There is tightness in the trapezius and rhomboids. Shoulder flexion is to 170 degrees with pain. She is not having any relief with physical therapy. Recommendation is for therapy in-house for range of motion and rotator cuff muscles to include modalities at the therapist's discretion. An MRI of the cervical spine was discussed as the pain could be coming from her neck. Strengthening exercises were ordered.

At reevaluation on May 8, 2009 the patient reports persisting significant pain. Additional PT has not been authorized. She reports sleep difficulty and neck pain from protecting her shoulder. She has failed analgesics, anti-inflammatory medication, cortisone injection and PT. Forward flexion is to 160 degrees.

There is moderate pain over the AC joint. Cross arm adduction is positive. Recommendation is for arthroscopic surgery.

Request for right shoulder arthroscopic surgery was not certified in review on May 18, 2009 with rationale that the ODG indications for surgery had not been met. A peer discussion was attempted but not realized.

Request for reconsideration is made in a letter dated June 9, 2009. At her initial visit the patient reported hearing a pop in her shoulder while putting an object on a high shelf. She was provided PT and an MRI. As she had good rotator cuff strength, conservative treatment was recommended. In April she had good shoulder strength but positive impingement signs despite PT with rotator cuff strengthening. On May 18, 2009 she still had significant pain that was affecting her activities and additional PT has been denied. She has failed injections, PT and anti-inflammatory medication. Imaging and clinically she has impingement and she would benefit from decompression and possible rotator cuff repair. Prior to her injury she was asymptomatic. If we cannot provide a surgery or physical rehabilitation she will be left with a painful and dysfunctional shoulder.

Request for reconsideration of shoulder surgery was not certified in review on June 16, 2009 with rationale that the current objective documentation does not support surgical intervention at 3 months post reported date of injury. Recommendation is for a conservative approach. The carrier dispute relative to the claim was mentioned. A peer discussion was attempted with the provider but not realized.

A supplemental report dated July 10, 2009 indicates some additional documentation has been made available. The patient states the employer is not letting her follow work restrictions, as advised. There are times when she has to lift over 10 pounds. She has forward flexion to 160 degrees, abduction to 140 degrees, strength of 5-/5 and pain with external rotation. Hawkins sign is positive; Neer's impingement sign is positive; Cross body adduction is positive.

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

According to The Official Disability Guidelines, 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.

ODG 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 range of motion, which requires both stretching and strengthening to balance the musculature. 2. Subjective clinical findings of pain with active arc motion 90 to 130 degrees and pain at night (Tenderness over the greater tuberosity is common in acute cases.) Objective clinical findings of weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area as well as positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). 4. Imaging clinical findings of conventional x-rays, AP, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in the rotator cuff.

The patient has attended 6 PT visits, which were not significantly helpful. The MRI shows small but deep bursal sided partial thickness tear of the supraspinatus tendon, interstitial partial thickness tear of the subscapularis tendon, subscapularis, supraspinatus, and infraspinatus tendinopathy, a subchondral glenoid cyst probably associated with a small focus of chondromalacia, mild subacromial spurring and mild acromioclavicular joint osteoarthritis and mild subacromial/subdeltoid bursitis. While pre-existing degenerative changes are noted, they have been rendered symptomatic by the industrial injury. The prior recommendation for additional conservative treatment has merit, however, the patient has been prevented from further PT since it has not been authorized by the carrier. A glenoid cyst rarely if ever responds to aspiration because the cyst is usually secondary to a superior labral/biceps tendon injury which was probably the "pop"---SLAP lesion. Rotator cuffs tears that involve more than 50% of the cuff often require surgery and although some respond to non-operative care, many do not. The patient has failed medication, injection and PT and meets ODG criteria for the requested intervention. I would recommend proceeding to a surgery at this time. Therefore, my determination is to disagree with the previous non-certification of the request for arthroscopic subacromial decompression right shoulder; arthroscopic distal clavicle resection right shoulder; arthroscopic rotator cuff repair right shoulder.

The IRO's decision is consistent with the following 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

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

ODG: Shoulder Chapter (7-16-2009) Surgery for Shoulder Impingement:

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. Arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff. 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. Operative treatment, including isolated distal clavicle resection or subacromial decompression (with or without rotator cuff repair), may be considered in the treatment of patients whose condition does not improve after 6 months of conservative therapy or of patients younger than 60 years with debilitating symptoms that impair function. The results of conservative treatment vary, ongoing or worsening symptoms being reported by 30-40% patients at follow-up. Patients with more severe symptoms, longer duration of symptoms, and a hook-shaped acromion tend to have worse results than do other patients. A prospective randomised study compared the results of arthroscopic subacromial bursectomy alone with debridement of the subacromial bursa followed by acromioplasty in patients suffering from primary subacromial impingement without a rupture of the rotator cuff who had failed previous conservative treatment. At a mean follow-up of 2.5 years both bursectomy and acromioplasty gave good clinical results, and no statistically significant differences were found between the two treatments. The authors concluded that primary subacromial impingement syndrome is largely an intrinsic degenerative condition rather than an extrinsic mechanical disorder.

ODG Indications for Surgeryä -- 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. 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 impingement.

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. 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. Difference between surgery & exercise was not significant. There is significant variation in surgical decision-making and a lack of clinical agreement among orthopaedic surgeons about rotator cuff surgery. 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. Patients with workers' compensation claims have worse outcomes after rotator cuff repair.

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.