

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: 3/18/2009

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

Left shoulder arthroscopy, cryotherapy unit purchase and CPM rental times 14 days

REVIEW OUTCOME

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

Overtuned (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 August 22, 2008 Imaging report, MR Arthrogram read by Dr.
- o January 23, 2009 Medical report from Dr.
- o January 28, 2009 Pre-cert request and surgery orders from Dr.
- o January 29, 2009 Record of peer-to-peer discussion from Dr.
- o January 30, 2009 Non-certification report for left shoulder arthroscopy
- o January 31, 2008 Letter of non-certification for left shoulder arthroscopy
- o February 3, 2009 Letter of medical necessity from Dr.
- o February 13, 2009 Request for appeal from Dr.
- o February 16, 2009 Non-certification report for reconsideration left shoulder arthroscopy
- o February 16, 2009 Letter of non-certification for reconsideration of left shoulder arthroscopy
- o March 11, 2009 Request for IRO
- o March 12, 2009 Assignment of IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is an employee who sustained an industrial injury to the right knee and left shoulder on xx/xx/xx when he jumped over a machine and fell and twisted his right knee. The mechanism for the left shoulder injury is not clarified.

The patient underwent right knee meniscectomy and minimal chondroplasty on May 27, 2008 with note of some intraoperative ACL laxity but good endpoint. He has also had left knee arthroscopy on an unspecified date with ACL reconstruction.

Left shoulder MR Arthrogram was performed on August 22, 2008 and shows a partial thickness tear on the inferior surface of the supraspinatus tendon with associated Hill-Sachs deformity but no associated marrow edema. Inferior surface tearing of the superior labrum with intact biceps tendon anchor. Moderate cartilage thinning diffusely in the anterior half of the glenoid.

The medical report of January 23, 2009 indicates the patient's left knee is improved. He reports persisting pain in the left shoulder. He reports popping and night pain. He describes a pain level of 8/10. Left shoulder abduction is to 120 degrees with weakness and pain. Jobst test is positive. Impingement signs are positive. Provocative tests are positive. There is tenderness at the AC joint and anterolateral acromion and deltoid atrophy. The diagnosis includes rotator cuff tear based on the MRI findings. Recommendation is to proceed with arthroscopic evaluation with a planned date of February 23, 2009.

On January 28, 2009 formal request was made for procedures of left shoulder rotator cuff repair, subacromial decompression, SLAP lesion repair, debridement, marcaine with epinephrine for interoperative control of hemostasis not as a nerve block for a diagnosis of left shoulder pain, left shoulder rotator cuff tear, shoulder impingement and left shoulder SLAP lesion. Request was also made for post-op DME of cryotherapy purchase and CPM unit rental for 14 days.

Per a note of January 29, 2009 the provider participated in a peer-to-peer discussion. The patient's case was reviewed including findings of decreased range of motion, positive provocative tests and deltoid atrophy. Imaging studies are consistent with rotator cuff tear, partial thickness Hill-Sachs deformity and inferior surface tear of the superior labrum. The patient is age xx and unable to perform his work duties.

Request for left shoulder arthroscopy, for rotator cuff repair, subacromial decompression, SLAP lesion repair or debridement was not certified in review on January 30, 2009. It was noted that the patient currently is reporting left shoulder pain, weakness, popping and night symptoms. Physical findings include anterior shoulder and AC joint tenderness, abduction limited to 120 degrees due to adhesive capsulitis, positive impingement and Jobst responses, deltoid atrophy, unmeasured weakness. A neurological examination has not been documented. Rationale for non-certification noted, while the patient was reported to have participated in conservative treatment of physical therapy and home exercises directed toward gaining full range of motion per the provider, there is no documentation of conservative treatment. It was not clear if the patient's shoulder pain is due to a partial thickness rotator cuff tear and SLAP lesion, considering he has evidence of prior shoulder dislocation, arthritic changes of the glenoid, deltoid atrophy and adhesive capsulitis without documentation of response to exercises. On this basis, the request was not considered medically necessary.

The provider responded with a letter of medical necessity dated February 3, 2009. The patient has a diagnosis of rotator cuff tear. His shoulder pops and he has pain at night. He has limited range of motion, positive Jobst test, positive impingement signs. Imaging shows partial tear of the supraspinatus tendon with Hill-Sachs deformity and inferior surface tear of the superior labrum - SLAP lesion. The surgery has been denied based on lack of documentation of physical therapy and home exercise program. The patient has undergone at least 6 months of conservative treatment, including a supervised rehabilitation program, home exercises, steroid injection and pain medications. He has been unable to reach full motion and continues with weakness and positive provocative signs. He would like to return to productive work.

Request for reconsideration for left shoulder arthroscopy, cryotherapy purchase and CPM use for 14 days was not certified in review on February 16, 2009 with rationale that no clinical records were available for review after the date of July 19, 2008. A left shoulder MRI reportedly shows tendonitis of the infraspinatus tendon and no rotator cuff tear. Impingement signs were positive with positive lift-off test and limited abduction, although range of motion was complete shortly after the accident. The remainder of the records submitted pertain to the patient's knee. There was no current information available in regard to the physical findings, imaging studies or conservative care that may have been provided. Given the lack of information the request could not be considered further.

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

Per ODG, 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. Cryotherapy is supported for up to 7 days post-op shoulder surgery. CPM is not recommended for the shoulder.

The medical records document left shoulder pain, weakness, popping and night symptoms. Left shoulder MR Arthrogram shows a partial thickness tear, Hill-Sachs deformity, inferior surface abnormality of the superior labrum, intact biceps tendon anchor, cartilage thinning diffusely on the anterior half of the glenoid. Per the provider, the patient has participated in time off work, physical therapy, home exercises and injection. The patient is almost one-year post injury and is unable to perform his prior job duties. Arthroscopic assessment with repair is a reasonable medical plan for this patient. Therefore, my determination is to overturn the previous non-certification of the request for left shoulder arthroscopy with cold therapy purchase and CPM unit rental for 14 days..

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

The Official Disability Guidelines - Shoulder Chapter - Updated February 19, 2008:

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)

Continuous Flow Cryotherapy

Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e, frostbite) are extremely rare but can be devastating. (Hubbard, 2004) (Osbaahr, 2002) (Singh, 2001)

Continuous Passive Motion

Not recommended for the shoulder. See the Knee Chapter for more information and Criteria for the use of continuous passive motion devices. (Raab, 1996) (BlueCross BlueShield, 2005)