

SENT VIA EMAIL OR FAX ON
Mar/11/2009

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopy Right Shoulder, Arth w/Debridement, Arth w/RCR, PO Shoulder Sling; Hemocyte Tissue

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Office note, Dr. 02/27/07

Office note, Dr. 03/13/07, 07/31/08

MRI right shoulder, 04/06/07

Office notes, Dr. 04/19/07, 05/31/07, 08/17/07, 09/18/07, 11/29/07, 01/10/08, 02/07/08, 03/13/08, 06/05/08, 08/14/08, 09/14/08, 10/02/08, 11/13/08, 12/11/08, 02/05/09

OR note, 07/16/07

Physical therapy note, 07/26/07

CT right shoulder, 02/21/08

EMG, 05/07/08

MMI, Dr. 10/31/08

Denial 01/14/09, 01/30/09

Request for IRO, 02/20/09

Associate Statement, 02/26/07

Injury Report, 02/27/07

Therapy, 02/27/07, 08/17/07, 08/31/07, 09/04/07, 09/21/07, 11/07/07,

Activity Status Report, 02/27/07, 02/07/08

Dr. 03/27/07, 04/11/07

X-ray, 07/10/07

History and Physical, 07/10/07

EKG, 07/10/07

Dr. 07/20/07, 07/30/07, 10/26/07, 04/10/08

11/29/07, 01/10/08, 02/07/08, 03/13/08, 04/10/08, 06/05/08, 07/31/08, 09/04/08, 11/13/08, 12/11/08

Peer Review, 04/17/08, 07/01/08

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female injured on xx/xx/xx when she tripped over tubes. She was treated for right shoulder pain after injury with only some improvement. A 04/06/07 MRI showed a full thickness tear of the supraspinatus and on 07/17/07 she was taken to the operating room for arthroscopic debridement of a SLAP tear, subacromial decompression and rotator cuff repair. The claimant attended therapy following surgery.?

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Dr. continued to follow the claimant post operatively. The claimant reported ongoing pain in the shoulder. On 11/29/07 Dr. provided a subacromial injection. On a 10/10/08 visit the claimant reported she had 1 week improvement with the injections. Her strength and motion were noted to be "good." When the claimant returned on 02/10/08 she continued to report pain. ?

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A 02/21/08 CT of the right shoulder with contrast documented suture anchors in the humeral head. There was no full thickness tear. The acromioclavicular joint was unremarkable.

There was a type I acromion and deformity of lateral acromion possibly surgical. A small amount contrast in the subscapularis was likely iatrogenic. 05/07/08 EMG studies showed mild median nerve involvement at the wrist. Following testing observation was recommended. ?

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On 8/14/08 Dr. saw the claimant again for pain. At that visit he noted that she really did not get relief from the subacromial injection even for a short time and he was doubtful that the pain was from the shoulder. He recommended a cervical MRI that was not certified.?

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The 09/14/08 noted there was pain in the trapezius to palpation and trigger point. Trigger point injections were given. On 10/02/08 Dr. McNutt indicated that the claimant got 3 weeks relief with subacromial injection. At that time exercise for the rotator cuff was recommended.

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On the 11/13/08 visit Dr. noted the claimant had improvement with the trigger point injection and he was not sure why. On that visit a subacromial injection was given at that time. That injection reportedly provided no relief. And surgery was recommended. ?

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Surgery was denied and on 02/05/09 Dr. reported the claimant had pain, weakness and loss of motion. On his examination there was reduced motion with positive Neer and Hawkins.?

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

The records document that this individual has previously undergone rotator cuff repair. A postoperative CT arthrogram did not reveal recurrence of the tear. Subsequently, this individual has had persistent pain complaints and inconsistent response to a variety of treatments. On one occasion a subacromial injection reportedly offered relief but on a second it did not. A trigger point injection reportedly offered benefit on one occasion and the treating physician suggested that he was unable to explain this. In the absence of a clear demonstrable lesion on imaging i.e. recurrent rotator cuff tear on CT arthrogram it would be difficult to recommend surgical arthroscopy with the simple purpose of cuff inspection and/or lysis of adhesions. Without clear documentation of the significant loss of motion suggestive of adhesive capsulitis or lysis of adhesions the request for surgical intervention in this particular case would neither be considered reasonable or medically necessary.

Official Disability Guidelines 2009 Updates: Chapter shoulder:

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.

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. PLU
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. PLU
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. PLU
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.) PLU
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). PLU
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-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)