



DATE OF REVIEW: 5/6/09

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for Hyalgan Injections – bilateral shoulders, using J7321, times 6.

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

Texas licensed 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 previously denied request for Hyalgan Injections – bilateral shoulders, using J7321, times 6.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice Case Assignment dated 4/30/09.
- Fax Cover Sheet dated 4/30/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 4/30/09.
- Medical Determination Letter dated 4/24/09, 4/14/09, 3/20/09.
- Examination Note dated 2/9/09, 4/23/08, 12/12/07, 11/1/07.

- Right Shoulder MR Arthrogram Findings dated 7/20/07
- Left Shoulder MR Arthrogram Findings dated 7/20/07.
- Left Shoulder Arthrogram Findings dated 7/20/07.
- Right Shoulder MRI Arthrogram Findings dated 7/20/07.
- Operative Report dated 6/4/96, 2/1/96.
- ODG Integrated Treatment/Disability Duration Guidelines (unspecified date).
- List of Providers Sheet (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury: xx-xx-xx

Mechanism of Injury: Electrical shock.

Diagnosis: Rotator cuff tear

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

The claimant is a male with a history of bilateral shoulder pain. He had a 02/01/96 right shoulder rotator cuff repair and a 06/04/96 left shoulder rotator cuff repair with decompression and acromioclavicular resection. A 07/20/07 MR arthrogram of the left shoulder showed a full thickness tear of the supraspinatus and infraspinatus tendons with marked retraction and atrophy of the muscles. There was a partial tear of the subscapularis with some atrophy of the muscle, a probable biceps tear and degenerative changes of the glenoid labrum and glenohumeral arthritis. A 07/20/07 MR arthrogram of the right shoulder documented a re-tear of the supraspinatus with tendon retraction, elevation of the humeral head, and atrophy of the supraspinatus and infraspinatus muscle. There was a partial tear of the subscapularis with some atrophy of the muscle and degenerative changes of the labrum and glenohumeral joint. In late 2007, the claimant was treated with Hyalgan for the shoulders bilaterally, noting in April 2008, that the injections had been of some benefit. On 02/09/09, Dr. noted that the Hyalgan worked for a while and then wore off. The claimant was having pain with activities of daily living and sleep. X-rays showed bilateral rotator cuff arthropathy. The claimant was to be referred for reverse total shoulder, but in the meantime, repeat Hyalgan was recommended. The records provided for review support that the patient was status post surgery to the right and left shoulders in the distant past (in 1996). In 2007, it was noted that the claimant had full thickness rotator cuff tears and degenerative changes in the glenohumeral joint. The claimant was previously treated with Hyalgan, which Dr. felt helped. It was then requested again. Review of the records provided and evidence based medicine would not support the medical necessity of Hyalgan injections into the bilateral shoulder joints as at this time. The utilization of this is considered experimental or under investigation. Per ODG, Hyalgan injections remain "under

study with promising results for glenohumeral joint osteoarthritis, but not recommended for rotator cuff tear or adhesive capsulitis.”

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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. Official Disability Guidelines (ODG), Treatment Index, 7th Edition (web) 2009 Shoulder - Hyaluronic acid injections.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).