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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/05/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right shoulder decompression, 1 assistant surgeon

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

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates, Shoulder

First report of injury, xx/xx/xx

Office notes, Dr. 3/10/09, 04/09/09, 04/30/09, 05/14/09, 06/02/09, 06/09/09, 07/09/09, 08/04/09, 08/24/09

Letter of medical necessity, Dr. 4/2/09

Right shoulder MRI, 4/6/09

Prescription for PT, 4/9/09

PT evaluation, 4/15/09

PT daily notes, 4/21/09, 4/22/09, 4/27/09, 4/28/09, 4/29/09, 05/13/09

Progress note, 4/29/09

Note, 8/31/09

Adverse Determination Letters, 9/3/09, 09/10/09

Request for reconsideration, 9/4/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female employed as a . She reported right shoulder pain after feeling a popping sensation on xx/xx/xx while lifting heavy material. The records indicated she had a previous right shoulder injury in xx/xx, which resolved with conservative treatment. There was also documentation of a C7 radiculopathy, which reportedly recurred after the injury in xx/xx. Right shoulder MRI on 04/06/09 noted mild acromioclavicular joint arthrosis with mild marrow signal bordering the articulation most likely indicative of symptomatic arthrosis, mild supraspinatus tendinosis with no evidence of partial or full thickness articular surface or

rotator cuff tear, no muscular atrophy and no labral or capsular pathology. The claimant treated conservatively with activity modification, therapy, oral steroids, NSAIDs, home exercise, and three cortisone injections. The claimant continued with radicular symptoms in the right upper extremity and a consultation was obtained for possible cervical epidural steroid injections and/or trigger point injections.

According to the medical records, electrodiagnostic studies were normal. Pain in the anterior shoulder with pain arc in abduction and forward flexion persisted along with audible popping with overhead motion and night pain. No instability was noted and the claimant denied any neck pain. Tenderness over the acromioclavicular joint, positive impingement and drop arm testing continued and right shoulder decompression with the use of an assistant surgeon was requested.

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

The patient does not meet the ODG criteria for this surgical procedure. The duration of her physical therapy is not well spelled out in the records. Her pain at night is not well confirmed. Furthermore, the records indicate there is considerable concern that there may be some overlap with the cervical problem here, and the cervical spine has not been imaged. Based on this information and finally the Milliman guidelines that would not allow for an assistant surgeon for acromioplasty, the reviewer would agree with the previous determination of the carrier in this case. The request does not meet the ODG or the Milliman guidelines. The reviewer finds that medical necessity does not exist at this time for Right shoulder decompression, 1 assistant surgeon.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates, Shoulder

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

ODG Indications for Surgery| -- 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

Milliman Care Guidelines®, Inpatient, and Surgical Care, 13th Edition, Assistant Surgeon for

shoulder decompression , no

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)