

US Decisions Inc.

An Independent Review Organization
9600 Great Hills Trail, Ste 150 W
Austin, TX 78759
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/10/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopic & Decompression & Debridement of the Right Shoulder

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, 2010 updates;
Shoulder- Surgery for Impingement.

Phone notes: Multiple

Office Note, Dr.: 07/14/10, 08/04/10, 09/07/10. adm 09/23/10

MRI Report: 07/21/10

Patient Information Sheet, undated

Therapy Note: 08/11/10, 09/13/10 and 10/06/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a reported right shoulder injury on xx/xx/xx when unloading and loading heavy bags. The claimant was seen by Dr. on xx/xx/xx for complaints of pain with right shoulder use. The claimant was noted to be a diabetic, tobacco user and allergic to Vicodin. Physical examination demonstrated active flexion to 80 degrees and abduction to 100 degrees; 3+ strength; and positive Neer and Hawkins. The claimant treated with Restoril, Motrin, Tylenol with Codeine and activity modification. Right shoulder MRI evaluation performed on 07/21/10 showed acromioclavicular joint and glenohumeral joint degenerative changes with findings contributing to impingement and minimal subacromial subdeltoid bursal fluid; posterior glenoid spurring without discrete labral tear; articular cartilage thinning and reactive marrow edema in superior humeral head; acromioclavicular with metallic artifact compatible with prior surgery; moderate biceps tenosynovitis with the biceps tendon normally located and anchor intact; superior labral degeneration and fraying; intact rotator cuff with tendinosis most prominently involving the subscapularis tendon; distal supra and infraspinatus tendons maintained; type I-II acromion contributing to impingement;

and the inferior glenohumeral ligament had minimal thickening suggestive of early adhesive capsulitis. The claimant underwent subacromial steroid injection on 08/04/10 with increased pain. Treatment continued with Aleve, Tramadol and 11 sessions of physical therapy. On 09/23/10 Dr. noted flexion to 100 degrees, external rotation to 60 degrees and internal rotation to 60 degrees. Recommendation was made for right shoulder arthroscopy with decompression and debridement. A physical therapy note dated 10/06/10 showed passive motion at 90 percent with active motion of flexion from 120-130 degrees, abduction from 90-100 degrees, external rotation from 45-50 degrees, internal rotation of 45 degrees and -4 to 4/5 strength. Request continued for arthroscopic management.

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

The requested Arthroscopic & Decompression & Debridement of the Right Shoulder is medically necessary based on review of this medical record.

This is a gentleman who has had ongoing right shoulder pain for the last four plus months, which occurred following picking up heavy bags. There are multiple office visits from Dr. as well as physical therapy records documenting positive impingement findings, weakness, and limited range of motion. He has undergone a 07/21/10 MRI right shoulder – the report describes degenerative changes as well as impingement. This claimant has had conservative care to include therapy, medication, and injections without improvement, and his physician has requested decompression surgery.

There are two prior reviews by other physicians to include a 10/08/10 review by Dr. and a 10/18/10 review by Dr., both of which have denied surgical intervention.

Official Disability Guidelines document the use of decompression surgery in patients who have positive impingement findings, failure of appropriate conservative care, and abnormal diagnostic testing, all of which appears present in this case.

Therefore, in light of the fact this claimant has had more than a four month history of pain and limitation in function and has failed appropriate conservative care and has positive physical findings and positive abnormal diagnostic testing, the requested Arthroscopic & Decompression & Debridement of the Right Shoulder meets the ODG indications for surgery and is found by this reviewer to be medically necessary.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates; Shoulder- Surgery for Impingement.

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.

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)