



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

Notice of Independent Review Decision-WC

**DATE OF REVIEW: 12-2-10**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Two left shoulder bursa injections between 10/15/10 and 12/14/10

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

American Board of Orthopaedic Surgery-Board Certified

**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.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- 1-1-10 Treatment notes from Hospital.
- 1-1-10 X-rays of the left shoulder.
- Physical therapy on 1-5-10, 1-7-10, 1-8-10, 1-10-10, 1-13-10, 1-15-10, 1-18-10, 1-27-10, 2-1-10, 2-8-10, 2-12-10, 2-17-10, 3-22-10, 3-23-10, 7-1-10, 8-23-10.
- Follow up visits at Medical Center on 1-5-10, 1-9-10, 2-5-10, 3-5-10, 3-23-10, 4-2-10, and 7-23-10.
- Physical therapy visit on 5-12-10.
- 6-4-10 MRI of the shoulder.
- 6-7-10 X-rays of the left elbow interpreted by MD.
- 6-4-10 MRI of the left foot.
- 6-14-10 DC., performed a Designated Doctor Evaluation.
- Medical Center follow up on 7-23-10.
- 10-1-10 MD., office visit.
- 10-7-10 DO., performed a Utilization Review.
- 10-15-10 MD., letter,
- 10-22-10 MD., performed a Utilization Review.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

1-1-10 Treatment notes from Hospital.

1-1-10 X-rays of the left shoulder shows no fractures or dislocations of the left shoulder.

Physical therapy on 1-5-10, 1-7-10, 1-8-10, 1-10-10, 1-13-10, 1-15-10, 1-18-10, 1-27-10, 2-1-10, 2-8-10, 2-12-10, 2-17-10, 3-22-10, 3-23-10, 7-1-10, 8-23-10.

Follow up visits at Medical Center on 1-5-10, 1-9-10, 2-5-10, 3-5-10, 3-23-10, 4-2-10, 7-23-10,

Physical therapy visit on 5-12-10.

6-4-10 MRI of the shoulder showed downsloped type II acromion. Capsule hypertrophy at the AC joint. Distal clavicular osteophyte of 3 to 4 mm. Mild rotator cuff tendinopathy and questionable partial thickening articular surface tear, perhaps follow up study with MRI arthrogram could be of additional benefit. Minimal subacromial/subdeltoid bursitis. Bicep anchor complex maintained. Subcortical cyst at the upper outer humeral head.

6-7-10 X-rays of the left elbow interpreted by MD., shows no apparent joint effusion or acute displaced fracture identified. If symptoms persist or occult fracture are suspected, follow up x-rays in 2-3 days are recommended. Alternative MRI can be performed.

6-4-10 MRI of the left foot shows osteoarthritic changes at the narrowed first metatarsal phalangeal joint. No acute fracture identified. Mild soft tissue edema at the plantar aspect of the fifth metatarsal phalangeal joint

6-14-10 DC., performed a Designated Doctor Evaluation. She certified the claimant had not reached MMI and estimated 8-14-10 as the date of MMI. The evaluator recommended additional therapy and an orthopedic consultation for the left knee, left shoulder and left ankle regions.

Medical Center follow up on 7-23-10 notes the claimant is status post injection to the left shoulder on 6-29-10. The evaluator recommended physical therapy 2 x. The evaluator also recommended ortho evaluation. The claimant is continued at work with restrictions.

10-1-10 MD., the claimant is a right hand dominant female (height: 5'6, weight: 180 lbs), who is employed as a xx. She reports injury to the left side of her body while sitting on divider rail and she was struck by a 15 passenger airport cart 9 months ago and was pushed by the impact to the right since it struck her on the left side. She has been treated with formal therapy with minimal improvement in ROM. She received an injection to her left shoulder that did not help with pain. She had an MRI that notes downsloped type II acromion, Capsule hypertrophy at the acromioclavicular joint, distal clavicular osteophyte of 3 to 4 mm, Mild rotator cuff tendinopathy and questionable partial thickness articular surface tear, minimal subacromial/subdeltoid bursitis. She is having pain to her left knee and is attending therapy for that as well. She presents for further evaluation and recommendations. The patient complains of the following symptom(s) and severity on a scale of 1-10: left shoulder pain (6), stiffness (6), weakness (5), located on the entire extremity. The symptom(s) occurs constantly predominantly during the daytime. The patient has a previous symptom located to the left knee requiring surgery torn ACL 15 years ago. She is currently off work. Previous

studies obtained include MRI. Previous treatment and their effect are: oral medications help the symptoms, therapy helps the symptoms, injection has no effect. physical exam of the shoulder: Motion: full in all planes. Strength: Left side strength tests: supraspinatus is 4+/5 manual motor power, infraspinatus is 4+/5 manual motor power, sub scapularis is 4+/5 manual motor power. Strength tests on the right side are normal. Stability: normal. Palpation: There is no tenderness on the right side, positive for AC joint, Gr. tuberosity on the left side. Provocative tests: Provocative tests are negative on the right side, positive for cross body AD/IR, cross body AD/EXT/IR, neutral impingement, 30 degree impingement, 60 degree impingement, 90 degree impingement, Yergason test but negative for speed test on the left side. Inspection: normal. Diagnosis: Left impingement and left shoulder AC. Plan: She reports injury to the left side of her body while sitting on divider rail and she was struck by a 15 passenger airport cart 9 months ago and was pushed by the impact to the right since it struck her on the left side. Her exam is consistent with left shoulder impingement from the SAS and ACJ. Recommend a second injection to both sites and resume therapy and a HEP. Will follow in one week for plain film x-rays of the left shoulder and for the injections. Continue NSAID.

10-7-10 DO., performed a Utilization Review. Per 10-1-10 medical report, the patient complained of left shoulder pain rate at 6/10. Physical examination to the left shoulder showed weakness in the supraspinatus, infraspinatus, and subscapularis muscles; tenderness to palpation on the acromioclavicular joint and greater tuberosity; positive for cross body adduction/internal rotation/extension, positive impingement test at 30, 60, and 90 degrees; and a positive Yergason test. The proposed injection is not medically appropriate for the patient based on the clinical information submitted for review. There was no clear rationale for requesting the procedure. Additionally, steroid injections do not provide long term outcomes. The patient reportedly had a steroid injection to the left shoulder on 6-29-10 but there was no Operative Report of the procedure and this reportedly did not improve the patient's symptoms and there is no point in pursuing a procedure that did not produce any clinical benefit. Also, there was no statement in the latest medical report as to how the patient's pain has created an impact to his ADL's. At this juncture, medical necessity of the requested medication is not fully supported by the clinical data presented.

10-15-10 MD., the claimant is right hand dominant female who works as a xx . She sustained a work related injury at xx/xx/xx. 9 months and 2 weeks from an injury to the left side of her body while sitting on divider rail as she was struck by a 15-passenger airport cart and was pushed by the impact to the right since it struck her on the left side. Her exam noted impingement from the left subacromial and ACJ on clinical exam that is well documented. Prior injections given by her referring doctor did not help. A subacromial and ACJ injections were requested for diagnostic and therapeutic reasons but denied. Her exam is unchanged with impingement from the SAS and ACJ. Plain films note left ACJ degenerative changes and a type two acromion. Prior MRI correlates with this and has an intact cuff. Please have an experienced reviewer review this request. If the injection is again denied, the will proceed with surgical recommendations.

10-22-10 MD., performed a Utilization Review. This patient had a work-related injury on xx/xx/xx. The 10-15-10 letter stressed that the patient has an unchanged physical examination of left shoulder impingement. However, submitted clinical information still does not establish the medical necessity of the request. There was still no clear rationale for the requested procedure and a description of how the patient's current pain has affected her functionality. There was still no operative report of the previous injection to the left shoulder done to objectively determine the patient's response to the said injection. As such, the appropriateness, medical necessity, and anticipated benefits of this requested procedure are not sufficiently substantiated and the previous determination is upheld.

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

BASED ON THE RECORDS PROVIDED, A SECOND INJECTION TO THE LEFT SHOULDER BURSA FOR DIAGNOSTIC AND THERAPEUTIC PURPOSES IS REASONABLE.

THE INTIAL INJECTION DID NOT GIVE LONG TERM RELIEF NOR WAS IT SUSPECTED TO DO SO. THE POSITION OF THE LAST INJECTION MAY HAVE NOT REACHED THE CORRECT SPACE. THEREFORE, ONE INJECTION TO THE LEFT SHOULDER BURSA IS REASONABLE AND MEDICALLY INDICATED.

**ODG-TWC, last update 11-8-10 Occupational Disorders of the Shoulder – cortisone injections:** Recommended as indicated below. Steroid injections compared to physical therapy seem to have better initial but worse long-term outcomes. One trial found mean improvements in disability scores at six weeks of 2.56 for physical therapy and 3.03 for injection, and at six months 5.97 for physical therapy and 4.55 for injection. (Hay, 2003) Variations in corticosteroid/anesthetic doses for injecting shoulder conditions among orthopaedic surgeons, rheumatologists, and primary-care sports medicine and physical medicine and rehabilitation physicians suggest a need for additional investigations aimed at establishing uniform injection guidelines. (Skedros, 2007) There is limited research to support the routine use of subacromial injections for pathologic processes involving the rotator cuff, but this treatment can be offered to patients. Intra-articular injections are effective in reducing pain and increasing function among patients with adhesive capsulitis. Although injections into the subacromial space and acromioclavicular joint can be performed in the clinician's office, injections into the glenohumeral joint should only be performed under fluoroscopic guidance. (Burbank, 2008)

Rotator cuff: For rotator cuff disease, corticosteroid injections may be superior to physical therapy interventions for short-term results, and a maximum of three are recommended. (Green-Cochrane, 2003) If pain with elevation is significantly limiting activities, a subacromial injection of local anesthetic and a corticosteroid preparation

may be indicated after conservative therapy (i.e., strengthening exercises and NSAIDs) for two to three weeks, but the evidence is not yet overwhelming, and the total number of injections should be limited to no more than three. ([van der Heijden, 1996](#)) ([Green-Cochrane, 2002](#)) ([Grant, 2004](#)) A recent meta-analysis concluded that subacromial corticosteroid injection for rotator cuff disease and intra-articular injection for adhesive capsulitis may be beneficial although their effect may be small and not well maintained. ([Buchbinder-Cochrane, 2003](#)) On the other hand, for post-traumatic impingement of the shoulder, subacromial injection of methylprednisolone had no beneficial impact on reducing the pain or the duration of immobility. ([McInerney, 2003](#)) Subacromial injections of corticosteroids are effective for improvement for rotator cuff tendonitis up to a 9-month period. They are also probably more effective than NSAID medication. Higher doses may be better than lower doses for subacromial corticosteroid injection for rotator cuff tendonitis. ([Arroll, 2005](#)) Another recent trial concluded that subacromial injection of betamethasone with lidocaine was no more effective than lidocaine alone in the treatment of patients with chronic rotator cuff tendinosis unresponsive to nonsteroidal anti-inflammatory drugs and physical therapy. They add that despite the popularity of this intervention, they were unable to document any benefit to subacromial corticosteroid injection in these patients. ([Alvarez, 2005](#)) Imaging-guided subacromial steroid injection may be of benefit in the short-term management of clinically and MRI-proven subacromial impingement, with 83% of patients reporting symptom relief at 6-month follow-up evaluation. Studies have shown that in many procedures performed without imaging guidance, the needle is not sited in the subacromial bursa, hence steroid is delivered to the peribursal soft tissues at best, and the outcome was better when the injection was accurately placed. ([Hambly, 2007](#)) Short-term pain relief provided by subacromial corticosteroid injection is greater vs placebo and is at least equal to that provided by treatment with nonsteroidal anti-inflammatory drugs (level of evidence, B). During physical rehabilitation, corticosteroid injections can help control pain from rotator cuff syndrome. Subacromial injection is helpful to distinguish between shoulder weakness caused by impingement (shoulder strength improves after injection) and true rotator cuff tear (no change in strength). ([Stephens, 2008](#)) Modest improvements in self reported complaints and range of motion after steroid injection seen in this and previous studies suggest that steroid injection is not a sufficient treatment strategy for patients with rotator cuff disease. Better outcome in terms of range of motion is reported after attendance at an active physical therapy program. ([Ekeberg, 2009](#))

***Adhesive capsulitis:*** For adhesive capsulitis, injection of corticosteroid combined with a simple home exercise program is effective in improving shoulder pain and disability in patients. Adding supervised physical therapy provides faster improvement in shoulder range of motion. When used alone, supervised physical therapy is of limited efficacy in the management of adhesive capsulitis. ([Carette, 2003](#)) ([Arslan, 2001](#)) While adhesive capsulitis has been managed with corticosteroid injections for over 50 years, there is debate over the use of single or multiple injections. This structured review concluded that multiple injections were beneficial until 16 weeks from the date of the first injection. Up to three injections were beneficial, with limited evidence that four to six injections were beneficial. No evidence was found to support giving more than six injections.

(Shah, 2007) In patients with adhesive capsulitis, injections into the glenohumeral joint have been shown to hasten the resolution of symptoms, but most patients have resolution of their symptoms without intervention, and interventions have not been demonstrated to improve long-term outcomes. Intra-articular injections are effective in reducing pain and increasing function among patients with adhesive capsulitis. Adhesive capsulitis is identified by limited active and passive range of motion of the shoulder. Although adhesive capsulitis may resolve spontaneously in 1 to 2 years, an intra-articular steroid injection can potentiate the effects of physical therapy. Stretching exercises should be reinitiated 1 week after the injection. (Burbank, 2008) (Burbank2, 2008)

*Impingement syndrome:* In a large randomized trial on the management of subacromial impingement syndrome by physical therapists there was no significant difference in the score on the shoulder pain and disability index at three months in participants who received a combination of injection and exercise compared with those who received exercise therapy alone, but significantly earlier improvements in pain and functional disability at one and six weeks were seen in the group given corticosteroid injection. If early pain relief is a priority, then adding local steroid injection to a course of physical therapy might be a good option. (Crawshaw, 2010)

**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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**