



Specialty Independent Review Organization

**AMENDED REPORT 7/13/2010**  
**Notice of Independent Review Decision**

**DATE OF REVIEW:** 7/9/10

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a right shoulder arthroscopy, RTC repair, SAD, DEC and a possible SLAP repair.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery who has been practicing for more than 10 years.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

The reviewer agrees with the previous adverse determination regarding the medical necessity of a right shoulder arthroscopy, RTC repair, SAD, DEC and a possible SLAP repair.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

xxxxxx:

These records consist of the following (duplicate records are only listed from one source):xxxx: (xxxxx)5/12/10 letter by MD, office notes by Dr. of 10/27/09 through 4/20/10, 9/14/99 right shoulder MRI report, 9/29/09 report by xxxx xxxx and an undated script for an orthopedic referral.

xxxxx: 5/5/10 denial letter, 5/25/10 denial letter and 4/30/10 and 5/18/10 letters by.

A copy of the ODG was not provided by the Carrier or URA for this review.

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

The claimant's painful positive impingement and drop arm shoulder findings have been noted to have been persistent despite therapy. The original injury was that of a fall onto the right upper extremity/shoulder. The therapy was performed under another provider's auspices. Slight weakness of the right shoulder has also been noted, along with AC tenderness. Diagnoses have included impingement, AC joint arthritis, partial cuff tear and a probable SLAP lesion. Surgical intervention has been proposed. As of 12/1/09, the claimant had failed a cortisone injection. Tendinopathy and a partial cuff tear were noted on a shoulder MRI dated 9/14/09 denial letters were reviewed, with rationale indicating that the degree of abduction and the number of PT visits were not delineated and that an MRA wasn't done.

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

There has not been adequate delineation of therapy records to support that therapy has actually been fully utilized and failed. In addition, there has not been evidence of any recent trials of cortisone injections. The labrum has not been identified as abnormal on the MRI, (an insufficient imaging study to fully assess the labrum). Without an imaging corroboration of a torn labrum and without adequate documentation of a failure of an adequate therapy trail and a recent trial of cortisone subacromial injection(s), the proposed procedures are not reasonably required.

**Reference:** ODGuidelines

#### **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. PLUS

**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. PLUS

**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. PLUS

**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.) 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 deficit in rotator cuff.

### **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.

[\(Washington, 2002\)](#)

Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See [SLAP lesion diagnosis](#). The advent of shoulder arthroscopy, as well as our improved understanding of shoulder anatomy and biomechanics, has led to the identification of previously undiagnosed lesions involving the superior labrum and biceps tendon anchor. Although the history and physical examinations as well as improved imaging modalities (arthro-MRI, arthro-CT) are extremely important in understanding the pathology, the definitive diagnosis of superior labrum anterior to posterior (SLAP) lesions is accomplished through diagnostic arthroscopy. Treatment of these lesions is directed according to the type of SLAP lesion. Generally, type I and type III lesions did not need any treatment or are debrided, whereas type II and many type IV lesions are repaired.

### **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)**