

# P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

## Notice of Independent Review Decision

### MEDICAL RECORD REVIEW:

**DATE OF REVIEW:** 06/02/2010

**IRO CASE #:**

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

This case was reviewed by a Orthopaedic Surgery Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

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

Right shoulder arthroscopy with subacromial decompression

### **REVIEW OUTCOME**

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

Upheld (Agree)

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

## **PATIENT CLINICAL HISTORY (SUMMARY):**

According to the medical records and prior reviews the patient is a female who sustained an industrial injury to the right shoulder on xx/xx/xx when lifting. Right shoulder MRI performed xxxxx was given impression: Prominent tendinopathy of the supraspinatus and infraspinatus tendons without a frank tear. The findings are significant for: There is a small amount of fluid in the subacromial bursa. There are hypertrophic changes of the AC joint, which extend inferiorly and cause impingement upon the supraspinatus tendon.

The patient was examined by the current provider on zzzzz. She has pain at the neck with turning her head and her right arm goes dead. Naprosyn and Neurontin have not been helpful. She is xxxx and xxxx pounds. Shoulder flexion is just past 90 degrees. Abduction is just less than 90 degrees. Internal rotation is to the ipsilateral buttock. Impingement sign is negative. Empty Can test is positive. Sensation is normal at the right hand. Grip strength is full. An MRI was reviewed which showed prominent tendinopathy of the supraspinatus and infraspinatus tendons. She appears to have right rotator cuff syndrome, impingement and pain and possible radiculopathy. A steroid injection was provided. She was informed that a neurosurgical consultation may be needed.

Progress notes indicate the patient called on xxxx and stated her shoulder was numb. On Jxxxx there was some concern if the neck and back were covered injuries. On xxxx she was waiting for authorization for a cervical epidural injection. She had a consultation on xxxx and was administered a cervical epidural injection. She reports increased neck and shoulder pain since the injection. The patient kept in phone contact over the following months. Most of the phone notes are illegible. On xxxx the carrier informed the patient was authorized for shoulder examination.

The record is bare regarding any treatment provided during the period of May 14, 2008 through March 2010, except for the summarized phone notes. The patient appears to have been under neurosurgical care during this period for her neck and underwent an anterior neck surgery at C5-6.

Medical report of June 23, 2008 indicates the patient has at least a partial rotator cuff tear at the right shoulder per MRI. She reported some benefit with an injection not the shoulder. She has some discomfort with shoulder range of motion. She may have a cervical radiculopathy and cervical MRI is recommended.

Cervical MRI of July 10, 2008 showed at C5-6, a disc bulge osteophyte complex that is slightly more focal centrally and causes cord contact, but no significant cord deformity or signal abnormality in the cord.

Medical report of July 28, 2008 noted the MRI findings correlate with the patient's radiographic findings. AN epidural injection as C5-6 was recommended and provided on August 8, 2008. On September 8, 2008 the patient reported no benefit with the injection. She feels incapacitated and not improved.

The patient underwent anterior discectomy, interbody fusion and plating at C5-6 on approximately September 25, 2008 with good results. On November 20, 2008 the provider notes she does not have any true radicular pain. She also has good shoulder range of motion on the right. Post-operative x-rays of January 5, 2009 showed a stable spine with no hardware complications.

On January 5, 2009 the patient was noted to have excellent recovery from her neck surgery. She is back working full time. Her major problem is right carpal tunnel syndrome on the right. On April 6, 2009 she has no radiating shoulder or arm pain, although she does have bilateral carpal tunnel syndrome. At 10 months post-op on August 6, 2009 the patient has no neck problems and no radicular shoulder or arm pain. Her CTS continues.

The patient was examined on March 10, 2010. She was last seen in May 2008 (by this provider) for right shoulder complaints. She had an MRI, which showed prominent tendinopathy of the supraspinatus and infraspinatus tendons. At that time she was given a steroid injection and was told the pain could be coming from her neck or shoulder. She did not improve and was sent for neurosurgical evaluation. She has had a surgery at C5-6. She is reporting recurrent right shoulder pain. Examination shows 90 degrees of flexion and abduction. Impingement test and Speeds tests are positive; Empty Can test is negative. She has had right shoulder pain for two years and recommendation is for right shoulder arthroscopy with subacromial decompression.

Request for right shoulder arthroscopy with subacromial decompression was considered in review on March 17, 2010 with recommendation for non-certification. Per the reviewer, the claimant is two years post injury. He has had a cervical surgery. He had a shoulder MRI in April 2008. The documentation contains no legible shoulder history of physical examination or legible information clarifying what conservative treatment has been provided such as PT, injections. Additional information was desired.

The provider submitted a letter of appeal dated March 25, 2010. The patient was first seen 5-9-08 complaining of right shoulder pain since lifting an object overhead on 3-25-08. MRI of 4-15-08 showed prominent tendinopathy of the supraspinatus and infraspinatus tendons. She was given a steroid injection. She was told the pain could be coming from her neck or shoulder and if she did not improve she would be referred to a neurosurgeon. She did see a surgeon and underwent anterior cervical surgery at C5-6. She returned on 03-10-10 reporting right shoulder pain. Exam showed 90 degrees of flexion and abduction. Impingement test was positive, Speeds test was positive and Empty Can test was negative. She has had pain for two years and

recommendation is for surgery with subacromial decompression.

Request for reconsideration right shoulder arthroscopy with subacromial decompression was considered in review on April 5, 2010 with recommendation for non-certification. Per the reviewer the patient is a 58-year-old female employee who developed shoulder pain two years prior after lifting. It appears the pain generator was difficult to determine as she was sent to a neurosurgeon. In spite of MRI which showed only minor degenerative changes at C5-6 she underwent a neck surgery on September 16, 2008. She continued to have numbness in the arm and difficulty holding things. There was a minimal evaluation of the continued shoulder pain and a request for arthroscopy. Initial request for arthroscopy was denied as there was no clear information that documented any conservative care or any clear indication for the surgery. The appeal letter re-states her brief history: She had a shot (no results stated) and she has 90 degrees of flexion and abduction, positive impingement tests and negative Empty Can test. It appears surgery is desired due to the duration of pain. ODG criteria for the surgery have not been met.

On May 3, 2010 the patient's brief history was again recounted as above and request was made for an IRO.

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

Per ODG, shoulder surgery can be warranted after 3-6 months of conservative treatment directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. There should be pain at night and pain with active arc motion 90 to 130 degrees. There should be weak or absent abduction, and tenderness over the rotator cuff or anterior acromial area and a positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). Imaging should show impingement.

Imaging, of two years prior, does show hypertrophic changes of the AC joint, which extend inferiorly and cause impingement upon the supraspinatus tendon. However, at examination two years prior impingement sign was negative. A steroid injection was provided two years prior, but the results were not reported. In August 2008 a cervical epidural injection resulted in increased neck and right shoulder pain (duration not reported). During the period of May 14, 2008 through March 2010, the patient was lost to treatment with the requesting provider. The patient was under neurosurgical care during this period for her neck and underwent an anterior neck surgery at C5-6. On March 10, 2010 the patient reported recurring right shoulder pain. The examination appears to be identical to the examination of two years prior and may not be an actual reexamination, but a citation of the record. A surgery has been requested without attempt of conservative treatment. Results of a cortisone injection have not been clarified. The patient is overweight and can be anticipated to have some restriction in shoulder motions. A current thorough shoulder examination is lacking. There is no documentation of absent or weak abduction. The patient should have an opportunity to regain motion with rehabilitative exercises before a surgery is considered. There is no documentation of PT to the shoulder. The clinical findings do not establish a medical necessity for the requested surgery per ODG criteria.

Therefore, my recommendation is to agree with the previous non-certification for right shoulder arthroscopy with subacromial decompression.

The IRO's decision is consistent with the following guidelines:

**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

The Official Disability Guidelines (04-14-2010) Shoulder Chapter - Surgery for Impingement:

Recommended as indicated below. Surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. Since this diagnosis is on a continuum with other rotator cuff conditions, including rotator cuff syndrome and rotator cuff tendonitis.

Arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff. This systematic review comparing arthroscopic versus open acromioplasty, using data from four Level I and one Level II randomized controlled trials, could not find appreciable differences between arthroscopic and open surgery, in all measures, including pain, UCLA shoulder scores, range of motion, strength, the time required to perform surgery, and return to work. Operative treatment, including isolated distal clavicle resection or subacromial decompression (with or without rotator cuff repair), may be considered in the treatment of patients whose condition does not improve after 6 months of conservative therapy or of patients younger than 60 years with debilitating symptoms that impair function. The results of conservative treatment vary, ongoing or worsening symptoms being reported by 30-40% patients at follow-up. Patients with more severe symptoms, longer duration of symptoms, and a hook-shaped acromion tend to have worse results than do other patients. A prospective randomised study compared the results of arthroscopic subacromial bursectomy alone with debridement of the subacromial bursa followed by acromioplasty in patients suffering from primary subacromial impingement without a rupture of the rotator cuff who had failed previous conservative treatment. At a mean follow-up of 2.5 years both bursectomy and acromioplasty gave good clinical results, and no statistically significant differences were found between the two treatments. The authors concluded that primary subacromial impingement syndrome is largely an intrinsic degenerative condition rather than an extrinsic mechanical disorder. A recent RCT concluded that arthroscopic acromioplasty provides no clinically important effects over a structured and supervised exercise program alone in terms of subjective outcome or cost-effectiveness when measured at 24 months, and that structured exercise treatment should be the basis for treatment of shoulder impingement syndrome, with operative treatment offered judiciously.

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