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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpt Lt RCR Subacromial decompression capsular release 29827 29826 29823

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 Workers' Comp 2010 updates, chapter shoulder, rotator cuff repair

Workers' Comp Services, 1/19/10, 2/16/10

MRI shoulder left, 10/20/09

Radiology report, 10/29/09

Physical therapy note, 11/13/09, 12/15/09

Office note, PA-C, 12/07/09

Office note, Dr. 01/12/10

Office note, Dr. 01/19/10

Peer review, Dr. 02/16/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male with complaints of left shoulder pain. The MRI of the left shoulder showed articular surface high-grade non-atrophic partial tear of the supraspinatus tendon with some interstitial extension. There was some edema within the subacromial/subdeltoid bursa that could have been sequelae of joint injection or reactive in nature. Full thickness pinhole component of the tear was not ruled out. It was noted that this could be best evaluated with MR arthrography. Mild infraspinatus tendinosis without focal tear was noted. The physical therapy note from 11/13/09 documented flexion 105 degrees, abduction 44 degrees, active elevation of the left upper extremity was 51 degrees and internal rotation to the left was to the hip pocket. On 12/07/09, Dr. evaluated the claimant for pain that interfered with his eating

and sleeping. The pain was located in the anterior portion of the shoulder and over the acromioclavicular joint. Examination revealed tenderness to palpation to the acromioclavicular joint, positive impingement and cross body tests. Forward flexion was to 100 degrees actively and passively to 150 degrees. External rotation was to 45 degrees and internal rotation was to the sacral area. A left acromioclavicular joint injection was performed. Diagnosis was adhesive capsulitis left shoulder, partial thickness rotator cuff tear left shoulder and grade 1 acromioclavicular joint separation of the left shoulder. Continued physical therapy was recommended.

On 01/12/10, Dr. noted that the range of motion of the shoulder was worse. Positive drop arm test and impingement tests were noted. Dr. reviewed the MRI and recommended surgery.

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

Records indicate a wide discrepancy in motion at numerous office visits. Passive flexion was noted to be near normal at 150 degrees on 12/07/09. The most recent records do not indicate active versus passive motion but rather stated the claimant had pain at the "extremes of motion." It is unclear what the limits of passive motion are for this claimant. The claimant reportedly had an acromioclavicular joint injection, but it is not clear if the claimant underwent a subacromial space injection. The MRI did not clearly show a full-thickness rotator cuff tear. It is unclear if the claimant has received a full course of conservative care. The reports of 10/10 pain would be atypical for the diagnoses noted. The patient does not meet the ODG indications for this surgery. The reviewer finds that medical necessity does not exist at this time for Outpt Lt RCR Subacromial decompression capsular release 29827 29826 29823.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter shoulder, rotator cuff repair

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

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)