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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/20/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left Shoulder Arthroscopy with Subacromial Decompression

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

08/23/10, 09/09/10

Review, Dr., 09/09/10

Review, Dr. ,08/23/10

MRI left shoulder, 07/21/10

Office notes, Dr., 08/12/10, 09/23/10, 09/30/10

Phone note, 09/07/10

Official Disability Guidelines Treatment in Workers' Compensation, Chapter: Shoulder

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a reported left shoulder injury on xx/xx/xx. Two mechanisms of injury were noted: moving heavy counter tops and using a drill in cramped space for a long period of time. The claimant reported a "pull" in his shoulder. Reference was made to initial treatment with Dr. that included x-ray, use of Advil, three physical therapy visits and referral for MRI study. Left shoulder MRI evaluation completed on 07/21/10 showed complete tear of the long head of the biceps tendon from the supraglenoid insertion with distal retraction at the level of the inferior biceps groove; moderate supraspinatus tendinosis, particularly on the undersurface anteriorly without evidence of a high grade partial or full thickness tear; moderate acromioclavicular degeneration; type II acromion with mild undersurface curvature; and intact labrum and articular surfaces. Dr., orthopedic, evaluated the claimant on 08/05/10. Physical examination demonstrated the left biceps muscle had a bulbous appearance along the lateral head; the left arm was neurovascularly intact; moderate pain with resisted elbow flexion; negative tests for labral tear; and negative cross chest, Hawkin's, lift off and

impingement tests. Recommendation was made for physical therapy and work restrictions. The claimant was evaluated by Dr. orthopedics, on 08/12/10 for left shoulder anterior pain, swelling and deformity. Physical examination demonstrated deformity; retraction of the biceps; weakness in abduction and external rotation; normal acromioclavicular joint; and swelling. Dr. reviewed the MRI and diagnosed left shoulder biceps tendon rupture and rotator cuff syndrome. Treatment options were discussed and the claimant accepted surgery. Work restrictions were assigned for ten-pound lift and carry with no overhead reaching.

Surgery was denied. Dr. saw the claimant again on 09/23/10 with notation of failed heat, ice, rest, activity modification and anti-inflammatories. Physical examination demonstrated tenderness about the greater tuberosity and the biceps tendon. Surgery continued to be recommended. The claimant was placed off work. Dr. saw the claimant on 09/30/10 for continued symptoms. The recommendation continued for work restrictions and no heavy lifting or use of left shoulder.

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

The requested Left Shoulder Arthroscopy with Subacromial Decompression is not medically necessary based on the information provided. A note from 08/05/10 indicates negative findings for impingement. More recent clinical examinations failed to document physical examination findings for impingement. A subacromial decompression is a procedure to treat a diagnosis of impingement. The only possible physical examination finding consistent with this diagnosis would be tenderness at the greater tuberosity. Standard physical examination findings, including Neer impingement sign and Hawkins testing are not noted. This claimant had a long head biceps tendon tear, which is generally treated nonoperatively, and it is not clear if the claimant has concomitant impingement or bursitis to require surgery. Furthermore, it is not clear if this claimant has received a subacromial corticosteroid injection, which is often both diagnostic to help confirm the diagnosis and potentially therapeutic to avoid a need for surgery. Therefore, the reviewer finds that Left Shoulder Arthroscopy with Subacromial Decompression is not medically necessary for this patient at this time.

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

Diagnostic Arthroscopy and Surgery for Impingement
Diagnostic arthroscopy

Recommended as indicated below. Criteria for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear

Acromioplasty: ODG Indications for Surgery| -

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)