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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient for Rt Shoulder Scope/Possible Labral Repair and Acromioplasty

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

ODG Guidelines and Treatment Guidelines
MRI shoulder 10/22/09
Office records Dr. 09/29/09-08/09/10
Letter by Xchanging 08/13/10, 08/20/10,
Preauth request Dr. 08/11/10
MRI upper extremity 11/14/08
AMR Peer Review 08/13/10, 08/19/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female with a work related injury date of xx/xx/xx being evaluated for a request for right shoulder arthroscopy, possible labral repair, and acromioplasty. The claimant's medical record contains a 09/28/09 orthopedic evaluation describing problems with her right shoulder since xx/xx/xx at which time she was doing some heavy work with the right dominant shoulder consisting of taking down and putting up shelving for display. According to the available MRI that will be reviewed later in this report the claimant has had prior surgery to the right shoulder based on metallic artifact that was documented. According to the claimant's history the treating physician states "there was a prior history of left rotator cuff repair in 2006. The reconstruction was performed and she had full return of function and resolution of symptoms prior to her injury of xx/xx/xx". The current evaluation is for the claimant's right shoulder. Returning to the claimant's 09/28/09 orthopedic examination the claimant has been through a home rehabilitation program as well as therapy and medications. The claimant's examination reveals "she does not like to abduct beyond 70 degrees". She is not clearly weak in abduction or external rotation. There is a negative belly-press sign and bear-hug sign. She could not bring her arm behind her back to perform a Gerber liftoff test. The claimant has full passive range of motion of her shoulder. She has

pain whenever the arm is brought into a horizontal plain and therefore has positive impingement sign, positive “slapprehension test” and discomfort with crossed arm adduction. She has some mild AC joint tenderness. Most of the tenderness is located over the anterior aspect of her shoulder. The claimant has positive biceps load test and when positioned supine has pain with abduction and external rotation. Conventional x-ray taken is negative for relevant osseous abnormalities. Reference is made to an 11/14/08 right shoulder MRI, which did not document a cuff tear. The claimant’s assessment is right labral tear versus subscapularis tear. The claimant was sent for an updated MRI arthrogram.

The claimant’s record contains a 10/22/09 right shoulder arthrogram. As noted above metallic susceptibility artifacts are identified indicating that the claimant’s prior surgery involved the right shoulder. The radiologist states that the rotator cuff appears intact with no tear. The long head of the biceps tendon is normally positioned. There is no labral tear identified and no paralabral cyst. The acromioclavicular joint appears intact without significant degenerative change. In summary, therefore, the radiologist’s review of the claimant’s MRI there is no documentation of a rotator cuff tear, no documentation of a SLAP tear, no evidence of acromioclavicular arthrosis, and no radiographic evidence of impingement.

After the MRI the claimant was again seen on 10/26/09 where the treating physician felt that the MRI was most suggestive of subacromial and subdeltoid bursitis which is in agreement with the radiologist interpretation. The claimant received a subacromial injection.

The claimant returned on 11/30/09 reporting no improvement from the subacromial injection either immediate or delayed. The claimant reports pain predominantly anterior. The claimant then received a Lidocaine injection to the glenohumeral joint with excellent relief of pain. The treating physician then concluded “that it appears that the primary source for pain is intraarticular and again that would lead towards the conclusion of a probable labral tear”. Treatment recommendation for the claimant was shoulder arthroscopy with arthroscopic labral repair. It is unclear as to how the treating physician arrived at the diagnosis or the proposed surgery considering the fact that the 10/22/09 MRI revealed no labral tear and that the long head of the biceps tendon is normally positioned.

On 07/09/10 the claimant was again evaluated with ongoing symptoms in her right shoulder. On that date the claimant had an evaluation of her left shoulder as well as an MRI that was performed on 05/27/10. Again, in this particular note reference is made to a history of left rotator cuff repair noting that she had a full return of function and resolution of symptoms prior to her injury of xx/xx/xx, however, on the claimant’s 09/28/09 evaluation it is indicated that her right shoulder was injured on xx/xx/xx.

The claimant’s final evaluation on 08/09/10 for the right shoulder indicated no improvement with conservative treatment. Diagnosis rendered for the claimant’s right shoulder is subacromial impingement, although there is a possibility that she has a labral tear. Again, the shoulder arthroscopy and labral repair versus debridement and possible acromioplasty has been recommended for the claimant.

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

ODG Guidelines are utilized with respect to SLAP lesion repair. The ODG Guidelines recommend surgical repair for type II lesions and type IV lesions if more than 50 percent of the tendon is involved. In the claimant’s case the MRI reveals no evidence of a SLAP tear and no evidence of any pathology with respect to the biceps tendon attachment to the labrum. Hence any surgical recommendation to address a “SLAP tear” in this claimant cannot be considered be medically necessary.

With respect to an acromioplasty ODG indicates that 80 percent of these individuals will improve without surgery. Conservative care is recommended for three to six months. Physical exam must show weakness in abduction, painful arc, positive impingement. Finally, ODG criteria require positive evidence of impingement on an MRI. In the claimant’s case

conservative treatment has been noted. The claimant has mild AC tenderness and tenderness over the anterior aspect of the shoulder and impingement signs. However, the claimant's MRI examination on 10/22/09 as noted above shows no evidence of a SLAP tear and no evidence of AC arthrosis and no documentation radiographically of impingement. Therefore, any surgical recommendation for this claimant with respect to an acromioplasty cannot be considered medically necessary.

Absent radiographic evidence of a SLAP tear or pathology with respect to the biceps tendon attachment to the labrum, absent evidence of AC arthrosis, and absent radiographic evidence of impingement, the request for Outpatient for Rt Shoulder Scope/Possible Labral Repair and Acromioplasty cannot be considered medically necessary.

Official Disability Guidelines 2010 Updates: Chapter shoulder:
SLAP Lesion Repair

Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved

Criteria for Classification of SLAP lesions:

- Type I: Fraying and degeneration of the superior labrum, normal biceps (no detachment); Most common type of SLAP tear (75% of SLAP tears); Often associated with rotator cuff tears; These may be treated with debridement.

- Type II: Detachment of superior labrum and biceps insertion from the supra-glenoid tubercle; When traction is applied to the biceps, the labrum arches away from the glenoid; Typically the superior and middle glenohumeral ligaments are unstable; May resemble a normal variant (Buford complex); Three subtypes: based on detachment of labrum involved anterior aspect of labrum alone, the posterior aspect alone, or both aspects; Posterior labrum tears may be caused by impingement of the cuff against the labrum with the arm in the abducted and externally rotated position; Type-II lesions in patients older than 40 years of age are associated with a supraspinatus tear whereas in patients younger than 40 years are associated with participation in overhead sports and a Bankart lesion; Treatment involves anatomic arthroscopic repair.

- Type III: Bucket handle type tear; Biceps anchor is intact

- Type IV: Vertical tear (bucket-handle tear) of the superior labrum, which extends into biceps (intrasubstance tear); May be treated with biceps tenodesis if more than 50% of the tendon is involved. (Wheeless, 2007)

ODG: Acromioplasty

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.

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)