

Wren Systems
An Independent Review Organization
3112 Windsor Road #A Suite 376
Austin, TX 78703
Phone: (512) 553-0533
Fax: (207) 470-1064
Email: manager@wrensystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: August 23, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right shoulder arthroscopy, AC joint resection, subacromial decompression, rotator cuff repair, labral repair, loose body removal and assistant surgeon PA

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 Worker's Comp, 16th edition, 2011 Updates, chapter shoulder, acromioplasty, Mumford procedure and SLAP surgery

MRI right shoulder 03/23/11

Workers' Comp Services, 07/14/11, 08/04/11

Records of Dr. 03/24/11, 04/26/11, 05/31/11, 07/07/11, 03/22/11

Physical therapy notes 04/11/11 to 6/27/11

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury of xx/xx/xx after falling. The claimant sustained a humeral fracture. The MRI of the right shoulder from 03/23/11 showed a complex fracture to the humeral head involving large axial oblique fracture through the neck and sagittal oriented fracture through the greater tuberosity and the majority of the cuff insertion. There was involvement of the lesser tuberosity. There was subtle cuff contusion versus small undersurface partial thickness tears involving the anterior most aspect of the cuff. The tendons of the cuff were grossly intact. There was prominent peritendinitis. There was acromioclavicular arthropathy inflammatory changes, mild medial and lateral arch narrowing. There was a grade 1 strain injury to the supraspinatus and subscapularis. There was abnormal appearance of the labrum anterior superiorly to anteroinferiorly, like substantial labral injury was present. On 03/22/11, Dr. stated that the fracture looked healed. Positive Neer and Hawkins testing was noted. The claimant was to begin physical therapy. On 04/26/11, the claimant reported anterior joint pain, occasional clicking and catching and pain forward across the motion of the elbow and with internal and external rotation. The claimant was seen on 07/07/11. The claimant noted anterior lateral tenderness and pain with the thumb in down position. There was acromioclavicular tenderness. Dr. has recommended right shoulder arthroscopy, acromioclavicular joint resection, subacromial decompression, rotator cuff repair, labral repair, loose body removal and assistant surgeon. The claimant has been treated with physical therapy.

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

Right shoulder arthroscopy, AC joint resection, subacromial decompression, rotator cuff repair, labral repair, loose body removal and assistant surgeon PA is not medically necessary, based on the records provided in this case. According to the ODG Guidelines for acromioplasty, partial claviclectomy and rotator cuff tear, conservative care should be rendered for at least three to six months in the setting of impingement syndrome. Claviclectomy Guidelines require documentation of pain at the AC joint, tenderness to the AC joint, pain relief at this level with injection of anesthetic for diagnostic therapeutic trial. Conventional films should show posttraumatic changes to the AC joint severe DJD of the AC joint or separation of the AC joint. Acromioplasty Guidelines require positive impingement signs on physical examination, temporary relief of pain with anesthetic injection. There is documentation of physical therapy.

However, there is no documentation of corticosteroid injections as required by the ODG Guidelines. The records are absent appropriate findings of symptomatic AC joint arthritis with relief by corticosteroid injection, impingement syndrome with relief by corticosteroid injection. Upon independent review, the reviewer finds that the previous adverse determinations should be upheld.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates, chapter shoulder, acromioplasty, Mumford procedure and SLAP 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 (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.

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 (Wheless, 2007)

Surgery for SLAP lesion :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.

Partial claviclectomy

Criteria for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint

1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS
2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS
3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS
4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates does not address assistant surgeon

Milliman Care Guidelines® Inpatient and Surgical Care

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)