

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/27/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopy Rt shoulder Possible subacromial decompression poss distal clavicle resection
poss Biceps tendosis RC repair biceps instability

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.

Shoulder

Peer Review . 03/17/11 , 04/14/11

Dr. OV 09/20/10 , 02/09/11

Dr. OV undated

Operative report 10/29/10

MR arthrogram right shoulder 06/07/10

MRI right shoulder 06/2006 , 03/02/11

Orthopedic OV 07/05/06 , 10/02/06 , 10/18/06 , 12/18/06 , 12/15/10 , 03/07/11 , 03/29/11 , 05/02/11

Physical Therapy records 07/08/06 , 10/03/06 , 01/15/07 , 11/10/10 , 01/12/11 ,

PATIENT CLINICAL HISTORY SUMMARY

This is a XX year-old male claimant who reportedly injured his right shoulder on XX/XX/XX when pulling an object. A MR arthrogram of the right shoulder performed on 06/07/10 showed a rotator cuff tear, acromioclavicular osteoarthritis, partial tear subscapularis at insertion and a small SLAP I type injury. Medications were prescribed and surgery was recommended. A right shoulder arthroscopic debridement of the labrum, open distal clavicle resection, open subacromial decompression and open rotator cuff repair was performed on 10/29/10. A follow up physician record of 12/15/10 noted the claimant with right shoulder pain and attending physical therapy with good passive range of motion.

A 02/09/11 physician record revealed the claimant with right shoulder pain particularly with therapy. It was noted that there was a pop felt during physical therapy. A palpable click was noted on examination. A repeat right shoulder MRI followed on 03/02/11 which showed severe tendinitis and partial tear of the cuff with inflammatory changes, changes about the acromioclavicular joint / distal clavicle, fraying and irregularity about the anterosuperior labrum and effusion adjacent to the anterior labrum likely synovial thickening / synovitis or

debris present. The attending physician recommended a right biceps tenodesis.

A follow up physician record dated 03/29/11 revealed the claimant going to physical therapy and having increased shoulder pain with an associated cluck of the shoulder. There was biceps tenderness with motion on examination and a clunk with external and internal rotation. A shoulder arthroscopy and tenodesis was recommended.

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

In this case it is very clear that initial symptoms in 20XX essentially resolved. The 12/20XX note regarding the right shoulder is absolutely unremarkable. The 06/2010 MR arthrogram certainly revealed some ongoing partial thickness injury, this prompted surgery in 10/2010, which included a repair. Excellent motion was regained in the physical therapy notes of early 2011. The MRI of the right shoulder of 03/02/11 revealed some changes quite consistent with the prior surgery. However the recent imaging study did not include pathology to substantiate all of the various surgical interventions recommended. Furthermore the claimant just underwent surgery in 10/10 and had excellent passive motion and good active motion by 01/11 with the therapist. There is no indication for a repeated surgery this soon out without some additional injury. The MRI findings are not unusual in a post-operative shoulder. There is certainly no specific documentation of biceps pathology. It is unclear how much symptomology might be arising from the AC joint and I do not see documentation of pain relief with an injection into the AC joint. There is no clear documentation of recurrent cuff pathology and no mechanism of injury for the same. In short the ODG are not satisfied for the multiple recommended surgical interventions. As such I would agree with the previous determinations in this case. The reviewer finds there is not a medical necessity at this time for the procedure: Arthroscopy Rt shoulder Possible subacromial decompression poss distal clavicle resection poss Biceps tendesis RC repair biceps instability.

Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates.
Shoulder

Surgery for impingement syndrome

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.

Surgery for 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)