

# P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

## **MEDICAL RECORD REVIEW:**

**DATE OF REVIEW:** 03/07/2011

**IRO CASE #:**

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

This case was reviewed by an Orthopaedic Surgeon, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Right shoulder scope SAD acromioplasty bursectomy outpatient 29826 29823

## **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overtuned (Disagree)

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 12-13-10 Right shoulder MRI read by Dr.
- o 12-17-10 Shoulder Examination notes from Dr.
- o 12-17-10 Initial Orthopedic Consultation report from Dr.
- o 01-12-11 Progress report from Dr.
- o 01-13-11 Fax cover for clinical records from Dr.
- o 01-24-11 Notice of Adverse Determination
- o 01-25-11 Fax cover for clinical records submitted for appeal consideration from Dr.
- o 02-08-11 Notice of Reconsideration Determination
- o 02-14-11 Progress report from Dr.
- o 02-22-11 Request for IRO from the Claimant
- o 02-22-11 Confirmation of Receipt of Request for IRO from TDI
- o 02-23-11 Notice to network of request for IRO
- o 02-23-11 Notice to P&S of Case Assignment from TDI

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records and prior reviews the patient is a male employee who sustained an industrial injury to the right shoulder on xx/xx/xx when he fell while getting down from a crane. He landed on his right shoulder.

Right shoulder MRI done on December 13, 2010 showed downslopping of the acromion which may predispose to impingement

syndrome. Bursal surface partial thickness tear at the supraspinatus tendon insertion. Possible intramuscular ganglion cyst versus partial tear at the anterior aspect of the infraspinatus muscle. Small fluid anterior to the infraspinatus muscle. Small subdeltoid, subacromial, and subcoracoid effusion. The labrum appeared to be normal.

Examination notes dated December 17, 2010 notes shoulder pain that travels to the upper arm resulting in decreased and painful ROM and decreased strength. He fell stepping down from a crane. He is using Ibuprofen and Tramadol. He has normal ROM with pain. Abduction strength is +3/5. Diagnosis is right shoulder impingement, bursitis and Type II acromion per x-rays. A subacromial injection, nine visits of PT and light duty were recommended. He will return in 3 weeks.

An orthopedic consultation was provided on December 17, 2010 for generalized pain about the right lateral and anterior shoulder regions. Strength is 4+/5 with exception of lateral abduction, which is 3+/5. There is tenderness over the bicipital groove. Impingement sign is positive. There is no sign of instability. MRI done December 13, 2010 showed some impingement and partial-thickness tearing of the supraspinatus tendon at the insertion. Impression is strain of the right shoulder with subacromial bursitis, impingement syndrome and probable partial-thickness cuff tear. Recommendation is for injection, PT 3 x 3, continue work restriction and return in 3 weeks.

The patient was seen on January 12, 2010. He relates no lasting improvement in his shoulder pain. The injection provided moderate relief but his pain has returned and is back at the 7/10 level. He is off work as there is no light duty. He has completed 9 visits of PT. The therapist is not recommending additional PT due lack of progress. He is using Relafen and Tramadol. He has 70 degrees of flexion and 50 degrees of extension. Abduction is pain-limited at 60 degrees. Strength is 4-/5 secondary to pain. He appears to give full consistent effort with testing. Impingement sign is markedly positive. He has chronic impingement and bursitis of the right shoulder. Recommendation is for subacromial decompression, bursectomy and acromioplasty followed by an aggressive rehab program. In the meantime, Relafen dosage will be increased to 759 mg.

Right shoulder surgery was requested on January 13, 2011.

Request for right shoulder scope SAD acromioplasty bursectomy outpatient 29826 29823 was considered in review on January 24, 2011 with recommendation for non-certification. Ten pages of medical records were reviewed. The patient fell when getting off a crane and landed on his right shoulder. He is using Relafen and Tramadol. He was provided a corticosteroid injection on December 17, 2010 with moderate amount of temporary relief. MRI of December 13, 2010 showed downsloping acromion process, impingement of the subacromial soft tissues, supraspinatus tendinopathy with a partial tear and subacromial bursitis. He attended PT without improvement. A peer discussion was realized with the provider. It is only two months since the injury. ODG criteria are reviewed. Rationale for denial states, the clinical information did not provide objective documentation of the patient's clinical and functional response from the mentioned subacromial injection that includes sustained an industrial injury to the pain relief, increased performance in the activities of daily living and reduction in medication use. The maximum potential of the conservative treatment done was not fully exhausted to indicate a surgical procedure.

Reconsideration for right shoulder surgery was requested on January 25, 2011.

Request for reconsideration right shoulder scope SAD acromioplasty bursectomy outpatient 29826 29823 was considered in review on February 8, 2011 with recommendation for non-certification. 20 pages of records including duplicates were reviewed. Rationale for denial states, there is no documentation provided with regards to the failure of the patient to respond to conservative measures such as evidence-based exercise program, as well as objective response to the pharmacological treatment. Furthermore, the clinical information did not provide objective documentation of the patient's clinical and functional response from the mentioned shoulder injection that includes sustained pain relief, increased performance in ADLs and reduction in medication use. The maximum potential of the conservative treatment done was not fully exhausted to indicate a surgical procedure.

The patient was most recently seen on xx/xx/xx, ten weeks post injury with persisting right shoulder and arm pain. Ranges of motion remain restricted secondary to pain. He appears to have an early frozen shoulder syndrome. He is tender over the lateral acromion process and head of the humerus. He can proceed with conservative care, which has not worked in the last 10 weeks, or proceed to a surgery. It would be wise to manipulate the shoulder during the surgery while he is anesthetized to be sure he does not have any hard endpoint, frozen shoulder or adhesive capsulitis.

Request was made for an IRO.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

ODG: Surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. There is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment. Conservative treatment of three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Pain with active arc motion 90 to 130 degrees and pain at night. 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). Imaging shoulder include conventional x-rays, AP, and true lateral or axillary view and Gadolinium MRI, ultrasound, or arthrogram showing positive evidence of impingement.

First and second line review denial rationale is essentially the same: The clinical information did not provide objective documentation of the patient's clinical and functional response from the mentioned subacromial injection that includes sustained

an industrial injury to the pain relief, increased performance in the activities of daily living and reduction in medication use. The maximum potential of the conservative treatment done was not fully exhausted to indicate a surgical procedure.

Nevertheless the patient has persisting disability (now over 90 days), a non-functioning shoulder with very limited ROM, imaging findings of downslopping acromion, bursal surface partial thickness tear at the supraspinatus tendon insertion, possible intramuscular ganglion cyst versus partial tear at the anterior aspect of the infraspinatus muscle, small fluid anterior to the infraspinatus muscle, small subdeltoid, subacromial, and subcoracoid effusion, and failure of lasting improvement with an injections and 9 visits of PT. Additional conservative treatment is not likely to resolve his shoulder condition and get him back to work. He also meets the criteria for MUA/release of adhesions with less than 90 degrees of active abduction.

Therefore, my recommendation is to disagree with the previous non-certification for right shoulder scope SAD acromioplasty bursectomy outpatient 29826 29823.

The IRO's decision is consistent with the following guidelines:

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN 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

The Official Disability Guidelines 02-17-2010 Shoulder Chapter:

Surgery for Adhesive Capsulitis:

Under study. The clinical course of this condition is considered self-limiting, and conservative treatment (physical therapy and NSAIDs) is a good long-term treatment regimen for adhesive capsulitis, but there is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment. Study results support the use of physical therapy and injections for

patients with adhesive capsulitis

#### Surgery for Impingement Syndrome:

Recommended as indicated below. Surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. Since this diagnosis is on a continuum with other rotator cuff conditions, including rotator cuff syndrome and rotator cuff tendonitis, see also Surgery for rotator cuff repair.

Operative treatment, including isolated distal clavicle resection or subacromial decompression (with or without rotator cuff repair), may be considered in the treatment of patients whose condition does not improve after 6 months of conservative therapy or of patients younger than 60 years with debilitating symptoms that impair function. The results of conservative treatment vary, ongoing or worsening symptoms being reported by 30-40% patients at follow-up. Patients with more severe symptoms, longer duration of symptoms, and a hook-shaped acromion tend to have worse results than do other patients.

#### 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.

#### Manipulation under anesthesia:

Under study as an option in adhesive capsulitis. In cases that are refractory to conservative therapy lasting at least 3-6 months where range-of-motion remains significantly restricted (abduction less than 90°), manipulation under anesthesia may be considered. There is some support for manipulation under anesthesia in adhesive capsulitis, based on consistent positive results from multiple studies, although these studies are not high quality.