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**Notice of Independent Review Decision
Amended IRO Decision**

DATE OF REVIEW: 12/18/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left Shoulder Arthroscopy (29826, 23420, 23410)

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

Certified by The American Board of Orthopedic Surgery

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective		29826	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Determination letters for initial and reconsideration requests
Physician notes dated 5/23/08, 7/15/08, 8/12/08, 8/19/08
MRI dated 5/30/08

PATIENT CLINICAL HISTORY:

This xx-year-old claimant sustained a left shoulder injury while at work onxx/xx/xx. On initial examination, it was noted that pain is moderate and

increased with motion; worse on elevation of the arm above the shoulder level. There is an MRI dated May 30, 2008 noting degenerative changes and bursa changes but no rotator cuff tear.

On 7/15/2008, the claimant received an injection and was to continue with physical therapy. On 8/12/2008, a physician noted that the claimant was no better after the injection; that the claimant had tendinitis with impingement and arthropathy unresponsive to conservative care. The physician felt that the degenerative and arthritic changes required surgical intervention. On 8/19/2008, the patient was evaluated and surgery (29826, 23420, 23410) was once again recommended.

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

As per the Division mandated Official Disability Guidelines, surgery for impingement syndrome is 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](#). ([Prochazka, 2001](#)) ([Ejnisman-Cochrane, 2004](#)) ([Grant, 2004](#)) Arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff. ([Gartsman, 2004](#)) This systematic review comparing arthroscopic versus open acromioplasty, using data from four Level I and one Level II randomized controlled trials, could not find appreciable differences between arthroscopic and open surgery, in all measures, including pain, UCLA shoulder scores, range of motion, strength, the time required to perform surgery, and return to work. ([Barfield, 2007](#)) 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. ([Hambly, 2007](#))

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.

In the professional opinion of the Reviewer, given the noted changes and treatment to date, this surgery is not supported by the Division mandated Official Disability 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
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**