



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 12/26/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of left shoulder arthroscopy with SAD scapular partial excision.

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

The reviewer is a board certified orthopedic surgeon (medical doctor) who has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of left shoulder arthroscopy with SAD scapular partial excision.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

– Dr

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr. : Dr. CT left shoulder-9/29/08; Neurodiagnostic testing – 10/21/08; Dr. office notes – 10/3/08-10/24/08; Dr. note – 12/12/08.

Records reviewed from : Denial letter – 11/3/08 & 11/18/08; Pre-authorization reconsideration request; Dr. office notes – 8/6/08-9/24/08; Outpatient

reassessment - 11/4/08; 8/6/08, 9/11/08, & 9/16/08 PT referral; 8/13/08 - 8/21/08 PT notes; and Pre-authorization request – 11/28/08.

A copy of the ODG was not provided for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx year old female injured twice on the job. The first injury occurred on xx/xx/xx when a 140 lb tube hit her left clavicle. The second injury occurred on xx/xx/xx when she slipped and fell onto her outstretched left hand and rolled onto her left shoulder. Dr. examined the patient on 8/06/08 and injected her left subacromial (SA) space. An MRI on 6/24/08 reported supraspinatus tendinosis. The patient reported no relief from the SA injection. The physical therapy program was very limited with no notation of the reason it was discontinued. An Injection into superomedial scapulothoracic bursa provided 2.5 weeks of relief. The radiologist interpretation of the CT was not compatible with the surgeon's interpretation.

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

The ODG recommends arthroscopy for an impingement syndrome 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 Arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff. 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. 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.

The reviewer indicates the following are reasons for the denial. (1) Subacromial injection provided no relief, which would have if impingement was significant

component of pain source. (2) winged scapula on neurologist's exam unaddressed and explains symptoms (3) CT radiologist's interpretation reveals no scapular deformity to resect. Therefore, these procedures are not medically necessary at this time.

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)