

Notice of Independent Review Decision

DATE OF REVIEW:

08/05/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder arthroscopy, subacromial decompression, distal clavicle excision CPT 29824.

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

Board Certified Orthopaedic Surgeon

REVIEW OUTCOME

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

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The requested procedure (left shoulder arthroscopy, subacromial decompression, distal clavicle excision CPT 29824) is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 07/20/10 MCMC Referral
- 07/20/10 Notice Of Assignment Of Independent Review Organization, , DWC
- 07/20/10 Notice To MCMC, LLC Of Case Assignment, , DWC
- 07/19/10 Confirmation Of Receipt Of A Request For A Review, DWC
- 07/16/10 Request For A Review By An Independent Review Organization
- 07/07/10, 06/09/10 fax sheets with notes from,
- 07/14/10 letter from, RN, Medical Case Manager,
- 07/06/10, 06/08/10, 05/25/10, 05/20/10 reports from, M.D.,
- 06/28/10 letter from, MS, OTR, CHT,
- 06/14/10 letter from, Claims Adjuster,
- 05/27/10 Worker's Compensation Insurance Verification,
- 05/20/10 left shoulder MR arthrogram, Diagnostic MRI
- Undated work Status Reports, DWC (07/06/10, 06/08/10 return to work dates)
- Note: Carrier did not supply ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a male who was reported to have sustained a work-related injury on xx/xx/xx. The described mechanism of injury was. The described mechanism of injury was

consistent with a shoulder sprain/strain. The first medical is dated 05/20/2010. It is an evaluation performed by M.D. Plain x-rays on that date were reported as normal. Dr. performed a steroid injection to the acromioclavicular joint and subacromial space on 05/25/2010. The injection worked according to the injured individual for three days and then his pain returned. A shoulder MRI revealed no rotator cuff tear, no SLAP tear, and a lateral downsloping of the acromion. Exam and imaging was felt to be consistent with impingement syndrome. Dr. noted on 06/08/2010 that the injury was now a workers' compensation injury on the date. The injured individual reported that work was slow at this time and he would have time to rehab after surgery so he decided to proceed with surgery. There is only one physical therapy note dated 06/28/2010. The injured individual has full range of motion, 5/5 motor strength, positive O'Brien's, and a mildly positive impingement. It is unclear how many treatments or the type of therapy the injured individual has undergone and his clinical response.

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

The injured individual is a male who has continued shoulder pain following a work-related injury on xx/xx/xx. The mechanism of injury was consistent with a shoulder sprain/strain. The evidence-based Official Disability Guidelines would have expected resolution of a soft tissue injury of this magnitude within six to eight weeks with conservative management. This would include NSAID's, activity modification, cryotherapy, possible steroid injection, and an active trial of physical therapy. MRI revealed a lateral downsloping of the acromion which is congenital and would predispose him to impingement syndrome. It did not reveal rotator cuff tear or SLAP lesion. Changes were noted in the distal clavicle felt to be consistent with stress injury or osteolysis. There is no information obtained from the injured individual regarding his outside activities to include weight lifting or repetitive overhead activities that would be a source of this change. His primary diagnosis appears to be impingement syndrome.

The injured individual has not failed a documented adequate trial of conservative treatment for at least three months and preferably six months. It would appear that the surgery has been requested by the injured individual more as a matter of convenience (slow at work, time to rehab).

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines

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. (Washington, 2002)

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. (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) A prospective randomised study compared the results of arthroscopic subacromial bursectomy alone with debridement of the subacromial bursa followed by acromioplasty in patients suffering from primary subacromial impingement without a rupture of the rotator cuff who had failed previous conservative treatment. At a mean follow-up of 2.5 years both bursectomy and acromioplasty gave good clinical results, and no statistically significant differences were found between the two treatments. The authors concluded that primary subacromial impingement syndrome is largely an intrinsic degenerative condition rather than an extrinsic mechanical disorder. (Henkus, 2009) A recent RCT concluded that arthroscopic acromioplasty provides no clinically important effects over a structured and supervised exercise program alone in terms of subjective outcome or cost-effectiveness when measured at 24 months, and that structured exercise treatment should be the basis for treatment of shoulder impingement syndrome, with operative treatment offered judiciously. (Ketola, 2009)