



Notice of Independent Review Decision

DATE OF REVIEW: 12/10/10

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for right shoulder arthroscopy and capsulorrhaphy, biopsy of shoulder tissue, shoulder decompression distal claviclectomy (CPT codes 29806, 23065, 29826, 29824).

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

Texas licensed 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)

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 previously denied request for right shoulder arthroscopy and capsulorrhaphy, biopsy of shoulder tissue, shoulder decompression distal claviclectomy (CPT codes 29806, 23065, 29826, 29824).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Insurance Review Report dated 11/12/10, 10/11/10.
Precertification Sheet dated 10/6/10.
Follow-Up Evaluation dated 9/29/10, 8/18/10, 6/28/10.
Right Shoulder MRI dated 6/15/10.

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: He hyperextended his right shoulder when he fell from a truck.

Diagnosis: Right shoulder outlet impingement, symptomatic acromioclavicular joint, symptomatic paralabral cyst in the posterior labrum, and posterior labral tear

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

This male sustained a right shoulder injury on xx/xx/xx. The mechanism of injury occurred when he hyperextended his right shoulder when he fell out of a truck. He had a diagnosis of right shoulder outlet impingement, symptomatic acromioclavicular (AC) joint, symptomatic paralabral cyst in the posterior labrum, and posterior labral tear. An MRI of the right shoulder on 06/15/10 showed a tear of the posterior labrum with associated paralabral cyst, mild hypertrophic tendinopathy of the supraspinatus insertion, mild capsular hypertrophy of the AC joint, and type II acromion. There was mild edema within the subdeltoid bursa that might represent early bursitis. The claimant treated with Dr.. He was seen on 06/28/10 due to persistent pain to the anterior and posterior aspects of the right shoulder. On exam the claimant had right shoulder posterior glenohumeral joint tenderness and tenderness of the greater tuberosity and AC joint. The claimant had 5-/5 deltoid, supraspinatus, external rotation, and internal rotation strength. Neer's and Hawkins' impingements tests were positive. He had pain with cross body adduction. X-rays showed a type 2 acromion.

Dr. noted that the MRI showed a tear of the posterior labrum and associated paralabral cyst extending back toward the spinoglenoid notch, fluid in the subacromial space, and edema in the AC joint. He recommended right shoulder arthroscopy with debridement of paralabral cyst, posterior labral repair, subacromial decompression and acromioplasty, and distal clavicle excision. The claimant followed up on 08/18/10. Physical therapy (PT) was ordered. At the 09/29/10 visit with Dr., the claimant noted no improvement with PT. He had difficulty with overhead activity and sleeping at night. He had pain to the anterior and posterior right shoulder. On exam there was tenderness at the glenohumeral region, greater tuberosity, and AC joint. There was pain with cross body adduction, and O'Brien test was markedly positive. Deltoid strength was 5-/5, supraspinatus strength was 4+/5, and external rotation strength 4+ to 5-/5. The impression was right shoulder outlet impingement, symptomatic AC joint, and symptomatic posterior paralabral cyst with posterior labral tear. The physician recommended right shoulder arthroscopy, acromioplasty, distal clavicle excision, debridement and repair of any rotator cuff tear seen, debridement of the paralabral cyst, and posterior labral repair. Dr. precertification request dated

10/06/10, however, was for right shoulder arthroscopy, capsulorrhaphy, biopsy shoulder tissue, shoulder decompression, and distal claviclectomy (CPT codes 29806, 23065, 29826, 29824). This procedure was denied on peer review of 10/11/10 noting that likely arthroscopic labral reconstruction was indicated, but it was unclear why distal clavicle excision was being performed as well as acromioplasty. A second peer review of 11/12/10 also denied the surgery, stating there was no indication for capsulorrhaphy or biopsy although arthroscopic labral repair and subacromial decompression would be indicated. The ODG gives criteria for the surgical requests as follows: "**Impingement:** 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: Recommend 3 to 6 months: Three months if continuous, six months if intermittent. PLUS 2. Subjective: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS 3. Objective: 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: XR. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement. - 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. ... **Capsulorrhaphy:** ODG Indications for Surgery™ -- Shoulder dislocation surgery: Criteria for **capsulorrhaphy** or Bankart procedure with diagnosis of recurrent glenohumeral dislocations: 1. Subjective: History of multiple dislocations that inhibit activities of daily living. PLUS 2. Objective: At least one: Pos apprehension findings. OR Injury- humeral head. OR Documented dislocation under anesthesia. PLUS 3. Imaging : Conventional x-rays, AP and true lateral or axillary view. Criteria for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint: 1. Conservative: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery not before 6 weeks.) PLUS 2. Subjective: Pain- AC joint; aggravation of shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS 3. Objective: Tenderness AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS 4. Imaging: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation. ... Surgery for SLAP lesions Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved Treatment of these lesions is directed according to the type of SLAP lesion. Generally, type I and type III lesions did not need any treatment or are débrided, whereas type II and many type IV lesions are repaired. The imaging data in this case is quite nonspecific. It appears that pain complaints are rather diffuse. A variety of surgical interventions has been recommended. Distal clavicle excision would be difficult to substantiate with only mild hypertrophy of the AC joint." There was no clear documentation of diagnostic injection outcomes. The indications for capsulorrhaphy and biopsy would be quite unclear as there would not appear to

be any clear-cut pathology from instability on the imaging studies or on the physical examinations. For all of these reasons, the proposed intervention cannot be recommended as medically necessary. The ODG guidelines are not satisfied, particularly for distal clavicle resection and capsulorrhaphy. The impingement guideline would not appear satisfied based on the absence of documentation of response to diagnostic injection. As such, the previous adverse determination is upheld for the previously denied request for right shoulder arthroscopy and capsulorrhaphy, biopsy of shoulder tissue, shoulder decompression distal claviclectomy (CPT codes 29806, 23065, 29826, 29824).

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
Shoulder: acromioplasty, capsulorrhaphy, partial claviclectomy, surgery for SLAP lesion
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).