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DATE OF REVIEW: 11/15/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopy, Shoulder, Surgical; Decompression of Subacromial Space with Partial Acromioplasty, with or without Coracoacromial Release

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Arthroscopy, Shoulder, Surgical; Decompression of Subacromial Space with Partial Acromioplasty, with or without Coracoacromial Release	29826		Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request	TDI	16	10/25/2010	10/25/2010
2	Appeal Denial Letter		4	10/13/2010	10/13/2010
3	IRO Request	TDI	10	10/18/2010	10/26/2010
4	Op Report		6	07/28/2009	02/02/2010
5	Office Visit Report	MD	8	09/02/2009	09/30/2010
6	Initial Request	MD	2	10/01/2008	10/08/2008
7	Initial Denial Letter	Managed Care	2	10/06/2010	10/06/2010

8	Initial Denial Letter		8	10/06/2010	10/13/2010
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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female patient who suffered an injury to her right shoulder on xx/xx/xx. The patient was in an elevator when she was hit on the left side. The ensuing trauma forced her right shoulder into the side of the elevator. She has undergone arthroscopic subacromial decompression, distal clavicle resection and labral debridement on 07/28/09 followed by subsequent adhesiolysis with labral debridement on 02/02/10. She suffers persistent symptoms of pain and diminished range of motion in the right shoulder, despite the surgeries and follow up rehabilitative care. Current exam findings show that impingement signs are reported as positive. Recent plain x-rays have suggested subacromial ossification. There is a request to preauthorize arthroscopic revision subacromial decompression. This request was denied on initial review and upheld on appeal. This is an IRO request for Arthroscopy, Shoulder, Surgical; Decompression of Subacromial Space with Partial Acromioplasty, with or without Coracoacromial Release.

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

Is right shoulder arthroscopic revision subacromial decompression medically necessary and appropriate at this time?

No. This patient has undergone 2 arthroscopic surgical procedures within the past 16 months. Her evaluation has included a consultation with another physician suggesting a possible cervical pathology being attributable for her ongoing pain. There is no recent special imaging study to document rotator cuff impingement or other shoulder pathology that would likely be amenable to the proposed surgical intervention. Symptoms have persisted in spite of NSAID medication, physical therapy and local injection. The likelihood of a favorable result from a third arthroscopic surgery is limited, and complications can be expected. Thus, noting the available clinical information on this case, together with the evidence based medical guidelines from ODG cited here, the prior denials of this request to preauthorize yet another arthroscopic surgery of the right shoulder were appropriate and should be upheld. The request for Arthroscopy, Shoulder, Surgical; Decompression of Subacromial Space with Partial Acromioplasty, with or without Coracoacromial Release is not medically reasonable or necessary.

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. [\(Ketola, 2009\)](#)

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.

[\(Washington, 2002\)](#)

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)

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of

Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on .