



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 3/30/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of a DX shoulder arthroscopy (29805).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer 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 disagrees with the previous adverse determination regarding prospective medical necessity of a DX shoulder arthroscopy (29805).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
MD and Clinic

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD: Referral Form – 1/24/XX, Progress Note – 1/24/XX, Diagnosis report – 1/24/XX; X-ray report – 10/15/XX, MRI report – 10/15/XX; MRI report – 8/6/XX; and Patient Review Past Notes – 7/15/XX & 10/13/XX.

Records reviewed from Clinic: Denial Letters – 2/15/XX & 2/24/XX; MD Request for Reconsideration – 2/15/XX; MD Physician Report – 1/20/XX; MD Patient Review Past Notes – 10/22/XX-12/18/XX; Rehabilitation Plan of Care – 12/20/XX, and Re-Evaluation Progress Note – 12/20/XX.

A copy of the ODG was not provided by the Carrier or URA for this review.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

On 1/24/XX, Dr. documented that the claimant had persistent right shoulder pain, rotator cuff weakness, positive drop arm sign, subacromial tenderness and 150 degrees of abduction. The MRI of the affected shoulder revealed tendinitis and a cyst. The patient "failed conservative treatment." An 8/8/XX dated left shoulder MRI discussed tendonitis, impingement and a partial rotator cuff tear. A 10/15/XX dated right shoulder MRI reflected tendinosis and an atypical apparent ganglion cyst, (potentially contributing to posterior impingement as per the radiologist) along with AC joint osteoarthritis. Records from Dr., from the summer, 20XX reflected bilateral shoulder pain and a history of treatment with medications and injection. More recent notes from Dr. dated 10/13/XX discussed the patient's right shoulder pain, subacromial tenderness and limited shoulder motion, and, NSAID intolerance. Denial letters reflected the lack of clear arthroscopic treatment plan and/or prior treatments attempts non-operatively. The reconsideration request by Dr. discussed the ongoing functionality deficit and inconclusive imaging studies. 1/20/XX dated records from a Dr. discussed pain, tenderness, positive impingement and a failure of prior treatments. Medical records from 12/20/XX were reviewed.

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

The claimant has recent evidence of a trial and failure of non-operative treatment including injection and physical therapy. The clinical and radiographic findings do support the proposed procedure as being medically necessary at this time. The cystic mass is positioned in such a location that it may be contributing towards posterior impingement, as with the underlying anatomical tendency towards anterior subacromial impingement due to the AC joint arthrosis. Therefore, both from a diagnostic (especially due to the not fully identified cystic mass) and likely therapeutic (impingement may be addressed) the procedure is medically necessary.

Reference: ODG Shoulder Chapter

Diagnostic arthroscopy

Recommended as indicated below. Criteria for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone.

Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care.

Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear. (Washington, 2002) (de Jager, 2004) (Kaplan, 2004)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

Surgery for impingement syndrome

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.

**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)