



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 8-16-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CPT 29826 Right Shoulder Subacromial Decompression

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

American Board of Orthopaedic Surgery-Board Certified

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 11-24-10 MRI of the right shoulder.
- 2-14-11 Surgery performed by MD.
- 2-24-11 MD., office visit.
- 3-29-11 MD., office visit.
- 5-12-11 MD., office visit..
- 6-14-11 MD., office visit..
- 7-12-11 MD., office visit.
- 7-18-11 MD., performed a UR.
- 7-26-11 MD., performed a UR appeal.

PATIENT CLINICAL HISTORY [SUMMARY]:

11-24-10 MRI of the right shoulder shows acromion anomaly and spurring associated with impingement. Associated subacromial/subdeltoid bursitis. Tears of the anterior and posterior glenoid labrum along with the free margins and articular surfaces.

2-14-11 Surgery performed by MD: right shoulder arthroscopy with subacromial decompression and acromioplasty. Right shoulder arthroscopy with arthroscopic biceps tenodesis.

2-24-11 MD., the claimant is 23 weeks out from right shoulder scope with decompression and biceps tenodesis. She is doing great. No real issues. She is to continue with therapy. She is to return to light duty only.

3-29-11 MD., the claimant is 6 weeks out from right shoulder scope with subacromial decompression and biceps tenodesis. She is doing well. No real issues. On exam, portal sites fully healed. Range of motion coming along okay but still having a fair

amount of loss of motion. Forward flexion to 95 degrees. Internal rotation to the posterior superior iliac spine. She is to continue working with her therapy. She will continue with activity modification and light duty only. The claimant was given a prescription for Naprosyn.

5-12-11 MD., the claimant is now 3 months out from right shoulder subacromial decompression and biceps tenodesis. She is having issues with her shoulder. She continues to have discomfort and her range of motion seems to have diminished and regressed. She is going to physical therapy at. On exam, she has adhesive capsulitis. Active and passive forward flexion to 95 degrees, external rotation to 5 degrees and internal rotation to the buttocks. Portal sites are fully healed. Plan: Unfortunately she appears to have developed adhesive capsulitis postoperatively. He recommended his standard protocol with steroid injection, which was provided. He provided the claimant with a prescription for Norco for pain and the claimant is to continue with physical therapy.

6-14-11 MD., the claimant is clinically slightly better. He was unsure why they would deny her therapy. She has postop adhesive capsulitis which would certainly benefit from further therapy. She did get better with the last injection and he recommended a repeat injection. He would like to avoid doing surgical capsular release but she is still having issues and does not progress upon her return on her next visit he may consider this. The left shoulder was injected.

7-12-11 MD., the claimant is seen for follow up of her adhesive capsulitis of the shoulder. The evaluator reported that the claimant is 5 months out from right shoulder subacromial decompression and biceps tenodesis. Unfortunately she has had issues getting authorized for any further therapy despite the use of her capsulitis postoperatively. She has not made any progress since her last evaluation. She is still having quite a bit of discomfort and pain. She has significant loss of range of motion. The claimant has 90 degrees of forward elevation, external rotator at 0 degrees, abduction to 10 degrees and internal rotation at 0 degrees. Strength is 3/5 at the right shoulder. The evaluator reported he did not think that therapy at this point would be of a huge benefit. She needed to have therapy over the past couple of months to get any benefit. She is started to scar in and has made no progress wither adhesive capsulitis of the right shoulder since her last evaluation. He felt that the way to get her back to work and feeling better would be a right shoulder arthroscopy with capsular release, subacromial decompression and lysis of adhesions with manipulation under anesthesia.

7-18-11 MD., performed a UR. He reports certification for right shoulder MUA, arthroscopy, capsular release and lysis of adhesions. Non certification for repeat right shoulder subacromial decompression. The evaluator reported that applicable clinical practice guidelines classify MUA and surgery for adhesive capsulitis of the shoulder as under study, but recommend consideration of their use for individuals failing conservative therapy, particularly postop. This individual has undergone right shoulder surgery twice and has postop adhesive capsulitis. Right shoulder MUA and arthroscopy for capsular release and lysis of adhesions is medically necessary treatment.

Additionally, review of literature points out that capsular contracture can cause non outlet type impingement symptoms when there is no primary impingement, and this individual has already undergone right shoulder subacromial decompression. Therefore, medical necessity for repeat right shoulder subacromial decompression as part of the treatment for her adhesive capsulitis is not convincingly established

7-26-11 MD., notes that UR appeal performed was upheld for right subacromial decompression. The evaluator reported that the claimant appears to have adhesive capsulitis; subacromial decompression would not likely be of benefit as there is no definite evidence of the presence of impingement and the patient has already had this procedure. Treatment should be focused on intensive exercises including passive help utilizing a rope and pulley. If no response, capsular surgery could then be an option.

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

APPLICABLE CLINICAL/ODG PRACTICE GUIDELINES DO SUPPORT AND SURGERY FOR INDIVIDUALS FAILING CONSERVATIVE THERAPY, PARTICULARLY POSTOP. THIS INDIVIDUAL HAS UNDERGONE RIGHT SHOULDER SURGERY TWICE AND HAS AN ESTABLISHED DIAGNOSIS OF POSTOP ADHESIVE CAPSULITIS. THERE IS NO DEFINITE EVIDENCE OF ANY RESIDUAL SUBACROMIAL-ASSOCIATED BONY IMPINGEMENT. A DIAGNOSIS OF "ACROMIAL IMPINGEMENT SYNDROME" HAS NOT BEEN ADEQUATELY ESTABLISHED ON ANY RESIDUAL OR RECURRENT BASIS. THE AP'S PATIENT HAS ALREADY UNDERGONE THE REQUESTED PROCEDURE. THEREFORE, MEDICAL NECESSITY FOR REPEAT RIGHT SHOULDER SUBACROMIAL DECOMPRESSION IS **NOT** REASONABLE OR NECESSARY AS PER APPLICABLE GUIDELINES.

References:

ODG-TWC, last update 8-8-11 Occupational Disorders of the Shoulder – Subacromial decompression: 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)

ODG-Shoulder Chapter-Surgery for adhesive capsulitis

Under study. The clinical course of this condition is considered self-limiting, and conservative treatment (physical therapy and NSAIDs) is a good long-term treatment regimen for adhesive capsulitis, but there is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment. (Dudkiewicz, 2004) (Guler-Uysal, 2004) (Castellarin, 2004) (Berghs, 2004) Study results support the use of physical therapy and injections for patients with adhesive capsulitis. (Pajareya, 2004) (Carette, 2003) (Arslan, 2001)

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)**