

Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 6TH 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Excision, distal clavicle, with acromioplasty and rotator cuff repair, left shoulder.
RCR 23420 23120

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. He has been in practice since 1982 and is licensed in Texas, Oklahoma, Tennessee and California.

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.

I do recommend certification of the request, as I do feel the patient was documented to have painful arc of motion and had impingement signs, which were questioned by Dr. XXXX, the patient has had conservative treatment extensively postoperatively and failed to respond, and the patient refused a corticosteroid injection. Therefore, I do feel this request is medically indicated.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 17 page fax 8/16/11 IRO request, 91 page fax 8/18/11 URA response to disputed services including administrative and medical records. Dates on documents range between 09/28/2010 and 08/16/2011.

PATIENT CLINICAL HISTORY [SUMMARY]:

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25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-4443

This male was injured xx/xx/xxxx. The patient subsequently has seen Dr. with an MRI ordered 12/13/10 noting a SLAP tear in the left shoulder. The patient subsequently was treated conservatively, failed to respond, and taken to surgery 02/17/11, where arthroscopic repair of the torn glenoid labrum was accomplished by Dr. Postoperatively, the patient underwent rehabilitation and also was noted to have carpal tunnel syndrome, right wrist, for which a carpal tunnel release was recommended.

As Dr. followed the patient, the shoulder failed to respond to conservative treatment. The patient was reported on 06/21/11 to have been in work conditioning and fell over with being in so much pain on the floor and had seizure-like symptoms with vomiting. EMS was called, and the patient was taken to the emergency room. Subsequently, the patient was sent for an MR/arthrogram 07/01/11. When compared to the prior MR/arthrogram, postsurgical changes were noted in the glenoid labrum and development of a partial-thickness supraspinatus tendon tear with AC joint edema and hypertrophy with impinging on the supraspinatus tendon. The patient was noted to have continued severe problems with raising the arm overhead.

On 07/06/11, Dr. noted the patient having impingement signs, positive cross-arm sign, and continued Tinel's in the right and left carpal tunnel with no noticeable atrophy in either hand. Surgical intervention with distal clavicle excision, acromioplasty, and rotator cuff repair was recommended. The patient has been noted to not want to consider an injection. He has been sent for rehabilitation for the shoulder, and as Dr. noted on 07/20/11, the patient continued to have impingement signs with weakness with overhead movement and positive cross-arm sign on physical examination.

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

The *ODG* guidelines for surgery for impingement syndrome includes conservative care, which this patient has had, painful arc of motion, which has been described, night pain that has been described, and has weak abduction with positive impingement sign and positive findings on imaging.

With the patient not wishing to have injection therapy at this time, I do feel the physical examination supports the requested distal clavicle excision, acromioplasty, and rotator cuff repair as necessary, as the patient has failed appropriate conservative treatment.

ODG Guidelines:
Surgery for impingement syndrome

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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)