



3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069
Ph 972-825-7231 Fax 972-274-9022

Notice of Independent Review Decision

DATE OF REVIEW: 1/3/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of 23120 Partial Claviclectomy, 23412 Repair of ruptured musculotendinous cuff, 29807 Arthroscopy, shoulder, surgical, repair of slap, 29822 Arthroscopy should surg, debrid limited, 29823 Extensive shoulder debridement, 29824 Arthroscopy, shoulder, distal claviclectomy, 29825 Arthroscopy with lysis of adhesions with ma, 29826 Decompression of Subacromial Space, 29827 Arthroscopic Rotator Cuff Repair.

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.

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 the prospective medical necessity of 23120 Partial Claviclectomy, 23412 Repair of ruptured musculotendinous cuff, 29807 Arthroscopy, shoulder, surgical, repair of slap, 29822 Arthroscopy should surg, debrid limited, 29823 Extensive shoulder debridement, 29824

Arthroscopy, shoulder, distal claviclectomy, 29825 Arthroscopy with lysis of adhesions with ma, 29826 Decompression of Subacromial Space, 29827 Arthroscopic Rotator Cuff Repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

& Texas Department of Insurance

These records consist of the following (duplicate records are only listed from one source):

Records reviewed from

Denials- 11/7/12, 12/5/12

Orthopaedic Surgery

Office Notes- 8/31/12, 7/30/12, 6/18/12, 6/11/11

Health Systems

Final Report- 8/6/12

Imaging

MRI Left Shoulder w/out Contrast- 6/11/11

Upper Extremity Joint- 8/6/12

Shoulder Complete 2+- 6/18/12, 4/16/12

Emergency Department

Physician Notes- 4/16/12

Records reviewed from Texas Department of Insurance

Texas Department of Insurance

Intake Paperwork

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

PATIENT CLINICAL HISTORY [SUMMARY]:

Provider records were reviewed. The patient was reportedly injured while lifting a patient on the DOI. After an attempted non-operative treatment trial and failure; the claimant underwent arthroscopic surgery of the affected left shoulder on 3/12/12. This included surgical repair of the rotator cuff and labrum, along with debridement. Due to some persistent symptoms, the patient underwent a postoperative left MRI scan on 8/6/12. This revealed postoperative changes and a partial cuff tear, labral tear and bursitis, with biceps tenosynovitis. On 8/31/12, the (diabetic) patient was noted to have persistent pain and shoulder popping (aggravated by Physical Therapy attempts) with positive impingement findings, drop-arm test and "exquisite" AC tenderness. The impression has included painful shoulder instability. Restricted activities were re-prescribed. Surgical intervention was considered. Subsequent denial letters discussed the lack of supportive MRI and the lack of detailed recent comprehensive non-operative treatment trial and failures.

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

Recommend approval of requested services. Persistently severe subjective findings of painful instability and impingement are associated with significant objective findings. The postoperative MRI corroborates these persistent findings despite reasonable and recent comprehensive non-operative treatment trials including therapy. The condition has persisted despite months of treatment including with medications, therapy and restricted activities. The proposed procedures are reasonable and medically necessary as per applicable ODG criteria.

Reference: ODG Shoulder Chapter

Surgery for Impingement Syndrome:

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)

Surgery for Rotator Cuff Repair:

Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:

- 1. Subjective Clinical Findings:** Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS
 - 2. Objective Clinical Findings:** Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS
 - 3. Imaging Clinical Findings:** Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.
- Criteria** for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR 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 (Tenderness over the greater tuberosity is common in acute cases.) 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 deficit in rotator cuff. (Washington, 2002)

Surgery for SLAP Lesion:

Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. The advent of shoulder arthroscopy, as well as our improved understanding of shoulder anatomy and biomechanics, has led to the identification of previously undiagnosed lesions involving the superior labrum and biceps tendon anchor. Although the history and physical examinations as well as improved imaging modalities (arthro-MRI, arthro-CT) are extremely important in understanding the pathology, the definitive diagnosis of superior labrum anterior to posterior (SLAP) lesions is accomplished through diagnostic arthroscopy. 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 debrided, whereas type II and many type IV lesions are repaired. (Nam, 2003) (Pujol, 2006) (Wheeless, 2007) Shoulder surgery for SLAP tears may not be successful for many patients. For example, of pitchers who failed physical rehabilitation and then went on to surgery just 7% were able to play as well as they had before, but for pitchers who just underwent physical rehabilitation, 22% were able to play as well as they previously had. (Fedoriw, 2012)

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)