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## Notice of Independent Review Decision

**DATE OF REVIEW:** 2/18/2013

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of Left shoulder arthroscopy (29826, 29823, 23412, 29999).

**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 agrees with the previous adverse determination regarding the prospective medical necessity of Left shoulder arthroscopy (29826, 29823, 23412, 29999).

**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 Texas Department of Insurance

Texas Department of Insurance

Intake Paperwork

Denials- 1/29/13, 12/17/12

Records reviewed

Surgery Reservation Sheet- 12/12/12  
Orthopedic Reports- 12/4/12, 10/31/12, 7/23/12  
Manual Muscle Strength Exam Shoulder- 12/4/12

CT Left Clavicle w/o Contrast- 10/29/12  
CT arthrogram left shoulder- 8/27/12  
MRI Left Shoulder w/o Contrast- 5/26/12

Records reviewed

Orthopedic Report- 1/18/13 (x2)  
Manual Muscle Strength Exam Shoulder- 1/18/13  
Pain & Recovery Clinic of North Houston  
Subsequent Medical Report- 6/21/12

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant was injured on xx/xx/xx in a motor vehicle accident, inclusive of the claimant's vehicle reportedly being struck and having rolled over. The most recent records from the provider were dated 1/18/13. Diagnoses include distal clavicle fracture status post Open Reduction with Internal Fixation, AC joint disruption with posttraumatic changes along with impingement syndrome and internal arrangement of the left shoulder with partial thickness cuff tear. The provider documented that the claimant has had a trial and failure of therapy, oral anti-inflammatories and multiple cortisone injections. Exam findings have most recently revealed positive impingement signs, tenderness, limited motion with weakness in abduction along with cross-chest adduction pain. The 5/26/12 dated shoulder MRI revealed "old traumatic changes of the distal clavicle, osteoarthritis and bony impingement." An 8/27/12 dated MR-arthrogram revealed similar findings. There is a consideration for diagnostic arthroscopy with subacromial decompression and distal clavicle resection. Denial letters revealed the lack of provision of recent and comprehensive non-operative treatment records.

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

Recommend denial of requested services. Despite the positive subjective and objective findings (inclusive of imaging documentation); corroborative evidence of the specific detailed trial and failure of the reported cortisone injection procedures and physical therapy has not

provided. Without provision of a recent comprehensive treatment protocol treatment notes in detail; the requested surgical procedures cannot be considered reasonable and/or medically necessary at this time, as per applicable guidelines referenced.

### **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)

### **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. (Washington, 2002)

#### **ODG Indications for Surgery™ -- 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)

**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)