



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 4/28/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of partial claviclectomy, repair of ruptured musculotendinous cuff-Chr, Arthroscopy shoulder surgical repair of slap, arthroscopy shoulder surg debrid limited, extensive shoulder debridement, arthroscopy shoulderdistal claviclectomy, arthroscopy with lysis of adhesions with mani, decompression of subacromial space, and athroscopic 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 partial claviclectomy, repair of ruptured musculotendinous cuff-Chr, Arthroscopy shoulder surgical repair of slap, arthroscopy shoulder surg debrid limited, extensive shoulder debridement, arthroscopy shoulderdistal claviclectomy, arthroscopy with lysis of adhesions with mani, decompression of subacromial space, and athroscopic rotator cuff repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

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

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

Organization:

Adverse Determination Letters – 3/1/13, 4/8/13

Pre-Authorization Request Form - undated

Physician:

Procedures to be Schedule – 2/8/13, 2/26/13

Science Center:

Progress Records – 1/14/13, 2/8/13

–Health System:

PT Script – 2/8/13

MD:

Exam Note – 1/29/13

Records reviewed from Orthopedic Clinic:

Physicians:

Clinic Documentation – 4/5/13

Problem List – 4/19/11

Allergy List – 4/24/09

Nursing Documentation – 3/27/13

Nursing Intake Documentation – 3/27/13

Medication Profile-Historical Meds – 4/18/13

DWC73

School of Medicine:

Patient Intake Form – 1/14/13

Clinic Notes – 1/14/13, 2/8/13

DO:

Radiology Report – 1/15/13

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The was injured on xx/xx/xx. He was engaged in activities as an at a xx when he landed on his side and injured his left shoulder. The claimant has had multiple diagnoses which have included arthritis, recurrent shoulder instability, shoulder dislocation, tear of the rotator cuff, along with SLAP lesion and bursal disorder. The most recent clinical findings are from 4/5/13. There were complaints of the shoulder possibly coming out of joint, with recurrent pain and popping. There was reduced range of motion with a positive apprehension sign and relocation tests, along with AC and glenohumeral joint tenderness and drop arm test weakness. Strength was 4+/5 and there was a positive impingement sign. Prior treatments

included six sessions of therapy and medications. On 1/29/13, MRI findings revealed an acute Hill-Sachs fracture and plausible "Bankart Lesion", along with a low-lying acromium and distal clavicle marrow edema. Denial letters have included a lack of comprehensive abnormal impingement findings, lack of recent comprehensive 3-6 months of non-operative treatments, along with imaging non-supportive of a cuff tear.

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

This is an active claimant/ with well documented recurrent shoulder subluxation/dislocation and impingement of his left shoulder. He has clinical and radiographic findings of instability, along with limited motion, weakness and overall evidence of impingement. The condition has persisted despite reasonable operative treatment inclusive of therapy, restricted activities and medications. The MRI findings fully support the clinical diagnoses provided by the treating provider. The combination of the clinical and imaging findings are of such a level of acuity and severity that the intent of overall clinical guidelines regarding treatment of the diagnoses has been met. At this point, reasonable, comprehensive and recent non-operative treatment has been tried and failed and the requested procedures (inclusive of addressing plausible cuff, labral and bursal pathology noted intra-operatively) are reasonable and medically necessary and supported by ODG criteria below.

ODG: Surgery for Impingement Syndrome:

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: Surgery for SLAP Lesions:

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)

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)

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

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)**