



MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 4/29/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of left partial claviclectomy (23120), extensive shoulder debridement (29823), arthroscopy with lysis of adhesions with Mani (29825), Decompression of subacromial space (29826) and arthroscopic rotator cuff repair (29827).

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. The reviewer has been practicing for greater than 10 years.

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 left partial claviclectomy (23120), extensive shoulder debridement (29823), arthroscopy with lysis of adhesions with Mani (29825), Decompression of subacromial space (29826) and arthroscopic rotator cuff repair (29827).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 3/28/12 to 1/23/13 imaging consult reports,

progress reports 12/2/11 to 3/20/12, progress reports 3/28/12 to 3/6/13, and two peer to peer notes.

IMO: 2/12/13 denial letter, 2/6/13 precert request, 2/6/13 surgery scheduling form, 3/20/13 denial letter, 3/11/13 precert request, 4/8/13 resubmission of precert request, 4/12/13 surgery scheduling form, and 3/27/13 progress report.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The female sustained a left shoulder injury on xx/xx/xx. The claimant reportedly had to suddenly stop her vehicle while driving and she sustained a left shoulder and upper back pain. Most recently the claimant reported ongoing pain, stiffness and weakness of the left shoulder, despite a trial of medications, injections, therapy and restricted activities. Examination findings revealed positive impingement signs along with slightly reduced shoulder flexion and external rotation. There was AC joint tenderness and posterior capsular tightness. The claimant was noted to have been developing a mild adhesive capsulitis/frozen shoulder. A diagnostic left shoulder ultrasound from 5-9-12 revealed a calcific deposit at the superior rotator cuff along with bursitis. A left shoulder MRI dated 11-19-12 documented calcific tendinitis at the rotator cuff without a tear. Denial letters discussed the lack of rotator cuff tear on imaging, along with the lack of AC joint tenderness.

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

The most recent combination of subjective and objective findings clearly evidence clinical impingement syndrome with adhesive capsulitis. Imaging studies revealing bursitis and calcific tendinitis have corroborated the findings. Over an extensive period (of months, up to a year); the claimant has had treatments including medications, cortisone injections, physical therapy and restricted activities. The treatments have been tried and failed. Applicable clinical guidelines clearly support the requested surgical procedures, as referenced below.

Reference: 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. Study results support the use of physical therapy and injections for patients with adhesive capsulitis. The latest UK Health Technology Assessment on management of frozen shoulder concludes that arthrographic distension (also called hydrodilatation), which involves controlled dilatation of the joint capsule under local anaesthetic with sterile saline or other solution such as local anaesthetic or steroid, guided by radiological imaging (arthrography), needs

more study. There is insufficient evidence to draw conclusions about the efficacy of distension (arthrographic or non-arthrographic) for frozen shoulder. In conclusion, few studies of distension were identified and only single studies of different comparisons were available. Based on one study of satisfactory quality there is a little evidence of potential benefit with distension compared with placebo. In conclusion, although the evidence available suggested potential benefit from capsular release, these studies were at high risk of bias and cannot be used to draw conclusions regarding the efficacy of this treatment for frozen shoulder.

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.

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.

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)