

Notice of Independent Review Decision

September 26, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

23120 Partial Claviclectomy. 23130 Acromioplasty/Acromionectomy Part

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. The physician has been in practice since 1998 and is licensed in Texas, Oklahoma, Minnesota and South Dakota.

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 medical necessity exists for each of the health care services in dispute.

Upon independent review, I find the previous adverse determination should be Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Received: 16 page fax 09/12/13 Department of Insurance IRO request, 36 pages of documents received via fax on 09/12/13 URA response to disputed services including administrative and medical. Dates of documents range from xx/xx/xx (DOI) to 09/12/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

Female who was injured reportedly on the job xx/xx/xx when she reportedly slipped and tried to break her fall with her left shoulder. She developed quickly

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severe pain about the left shoulder along with other symptoms of burning and tingling. Treatments to this point have included physical therapy along with subacromial injection. Medical records indicate she got no lasting relief from the steroid injection but did apparently have short-term good but not total relief from the local anesthetic portion of the injection. MRI specifically indicates there is an absence of an impinging lesion. There is evidence of partial rotator cuff tears and “minimal” degenerative changes about the acromioclavicular joint.

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

The patient has obvious signs and symptoms that would be consistent with impingement syndrome, including tenderness to palpation over the rotator cuff and anterior acromial area along with a positive impingement sign. The patient also did get temporary relief of pain with a subacromial injection. Additionally, there is pain with overhead activity and pain at night. It is noted, however, that the MRI findings specifically indicate the absence of an impinging lesion. Thus, the documentation would not support surgery for impingement syndrome, according to *Official Disability Guidelines*.

With regards the partial distal clavicle excision, again the patient would seem to exhibit positive signs and symptoms of acromioclavicular joint pain with localized tenderness. Once again, however, there is no evidence of significant degenerative joint disease of the AC joint itself or any evidence for separation of the AC joint, which would be a requirement for partial clavicle excision, according to *ODG* guidelines.

ODG -TWC

ODG Treatment

Integrated Treatment/Disability Duration Guidelines

Shoulder (Acute & Chronic)

Partial claviclectomy (Mumford procedure)	<p>See Surgery for shoulder dislocation for more information and references.</p> <p><u>ODG Indications for Surgery™ -- Partial claviclectomy:</u> Criteria for <u>partial claviclectomy</u> (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint:</p> <p>1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS</p> <p>2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS</p> <p>3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS</p> <p>4. Imaging Clinical Findings: Conventional films show either: Post-traumatic</p>
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	changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation.
Surgery for impingement syndrome	<p>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)</p> <p>ODG Indications for Surgery™ -- Acromioplasty:</p> <p>Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.)</p> <p>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</p> <p>2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS</p> <p>3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive</p>

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	<p>impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS</p> <p>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.</p> <p>(Washington, 2002)</p>
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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)