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Notice of Independent Review Decision

DATE: September 22, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Shoulder Arthroscopy/Surgery (Diagnostic Arthroscopy with Acromioplasty, Distal Clavicle Resection, Extensive Debridement, Lysis of Adhesions Possible Revision Rotator Cuff Repair, and Indicated Procedures #29827, 29826, 29824, 29823, 29825, 29821, 29820) and DME Supply or Accessory, NOS (Purchase of Abduction Pillow Sling and Rental of a Cryotherapy Unit

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

The reviewer is certified by the American Board of Orthopaedic Surgery with over 42 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his left shoulder while working on xx/xx/xx.

12/06/13: Operative Report. DIAGNOSIS: Bicipital tenosynovitis, rotator cuff tear, acromioclavicular joint sprain, impingement syndrome, rupture long head biceps. PROCEDURES: Left shoulder arthroscopy with extensive debridement, distal claviclelectomy, acromioplasty, and arthroscopic rotator cuff repair and open biceps tenodesis.

01/15/14: The claimant was evaluated postoperative follow up. On exam, there was no swelling, tenderness, or warmth and the wound was clean and dry. Neurovascular intact and passive motion limited (FF90, ABD76, ER @ side 25). He was instructed to continue one visit per week for therapy for two more weeks and then transition to a home exercise program for six weeks. He was to continue

with limited at work, continue sling use, and wear the waist strap at night. He was allowed to ambulate with the sling off to allow pendulum range of motion activities. He was to check back at three months postop.

02/28/14: The claimant was evaluated. His reviewed medications listed included hydrocodone. Physical exam only documented "no swelling, tenderness, or warmth and wound clean and dry, neurovascular intact and passive motion limited (PFF95, PAbd75, PER60, PIR30). He was given a prescription for hydrocodone 10 mg – acetaminophen 325 mg 1-2 p.o. q. 4-6h. prn pain #50. DISCUSSION: Continue to work on PROM. Light duty. RTC after 3/6.

04/28/14: The claimant was evaluated. He reported continued pain and stiffness in the left upper extremity at EROM and decreased shoulder ROM and upper extremity function. On exam, ROM restrictions: Left shoulder flexion 132, abd 85, ER 35 at 0 degrees abduction. There was EROM pain and hard end feel with PROM. Strength deficits: Flexion 3 to 3+/5, abduction 3 to 3+/5, ER 3/5. Capsular restriction posterior, inferior GH capsule. Decreased functional lifting, decreased OH reach. PLAN: Treatment plan consisting of possible shoulder injection followed by progressive ROM, mobilization, and strengthening of scapular stabilizers, RTO and UE musculature.

04/28/14: The claimant was evaluated for "pain since Friday." On exam, there were no abnormalities on left shoulder inspection. There was no tenderness to palpation. She had limited PROM of the left shoulder. Hawkin's test, Neer's test, O'Brien's, Speed's tests were negative, and empty can sign were negative. Subscapularis strength tests were normal. Anterior slide test, Yergason's test negative. No dislocation or laxity. Anterior relocation test negative, apprehension test negative. Load and shift test negative. Posterior apprehension test negative and load and shift test negative. Sulcus sign negative External rotation at 0 deg. of abduction 4/5 and 90 deg. Of abduction 4/5 and abduction 4/5, adduction 4/5, flexion 4/5, extension 4/5, internal rotation 4/5, and scapular elevation 4/5. He had normal reflexes and sensation. He was to increase PT; popping and pain concerning. Will consider MR arthrogram in a couple of months if not improving.

05/22/14: The claimant was evaluated. He continued to display left shoulder dysfunction, capsule restriction, and limited scapulothoracic mechanics. It was difficult to determine the integrity of shoulder structures due to pain and limited mobility – joint mechanics. Response to current treatment, moderate. Slow to progress.

06/12/14: Left Shoulder Arthrogram MRI report. IMPRESSION: Previous biceps tenodesis. Prior acromioplasty. Normal labrum. Beginning at the anterior margin of the supraspinatus tendon, there is a 75-80% articular-sided partial tear. This tear extends posteriorly in a horizontal fashion through the supraspinatus tendon and into the more anterior fibers of the infraspinatus tendon. This articular-sided partial tear also tracks medially along the long axis of the fibers.

06/19/14: The claimant was evaluated. He reported that he had a painful episode with PT after surgery where the therapist "pulled on his arm and pushed his shoulder." On exam, he had tenderness to the subacromial bursa and subdeltoid bursa. AROM Left: External rotation at 0 deg. Of abduction (30 deg.) and 90 deg. Of abduction (60 deg.), internal rotation (L1 deg) and at 90 deg. Of abduction (15 deg), and abduction (95 deg), and extension normal and internal rotation normal. Hawkin's test positive. Neer's test positive, and empty can sign positive. Strength Left: External rotation at 0 deg of abduction 4/5 and 90 deg of abduction 3/5 and abduction 5/5, adduction 5/5, flexion 5/5, extension 5/5, internal rotation 5/5, and scapular elevation 5/5. Sensation was normal. He was to continue PT and current work restrictions and follow up in six weeks.

06/22/14: Note by PT indicated that he was to hold therapy at current time due to plateau in progress.

07/29/14: Note by PT indicated that the claimant reported that his shoulder was doing better and he was working at modified activity. He had improving AROM and strength. He reported that he was performing his home exercise program as instructed and was tolerating it well.

07/31/14: The claimant was evaluated. He reported having dull pain and difficulty with abduction. He had pain with all ROM. His exam was unchanged since previous visit. noted, "I am concerned about the continued pain and weakness the patient is having nearly eight months after his surgery. The MR arthrogram shows no pullout of the anchors but a residual area of 75-80% thickness partial articular tear of the supraspinatus. We decided to wait after his last visit to see if it would improve with continued, time, activity modification in therapy. However, he does not seem to have improved. I recommend diagnostic arthroscopy with debridement, lysis of adhesions, 'or sect to me' and possible revision rotator cuff repair."

08/12/14: UR. RATIONALE: The patient has had surgery. There is recurrent pain. The MRI showed postoperative changes. There has already been a distal clavicle resection and rotator cuff repair. There was partial thickness cuff tear on the MRI. This may represent the postoperative changes. There is no full thickness tear. This is request for #29821, 29820, and 29823. This is considered unbundling as each of these are redundant codes. The request does not meet evidence-based guidelines. The surgery is not medically necessary, therefore, the postoperative durable medical equipment (DME) is not medically necessary.

08/18/14: UR. RATIONALE: The provided document states the patient has undergone distal clavicle resection and acromioplasty with rotator cuff repair. Synovectomy and lysis of adhesions is included in #29823. The diagnostic arthroscopy and revision rotator cuff repair may be medically necessary given persistent shoulder pain, MRI arthrogram findings, and failure of conservative measures. The discussion with the treating surgical team indicates painful shoulder arc of motion, mild/painful RC motor testing and diagnostic response to

injections. They recognize resubmission with the appropriate codes is warranted. As submitted, the requested surgical procedure is not medically necessary.

08/18/14: UR. RATIONALE: As the surgery is not medically necessary, the postoperative DME is also not medically necessary. Based on the provided documentation, discussion with the treating surgical team, and review of evidence based guidelines, the requested procedures are not medically necessary as discussed above.

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

The previous adverse decisions are upheld. According to ODG criteria, a diagnostic arthroscopy is not indicated. Repair of partial cuff tear is not indicated and he has had surgery to correct any impingement. He has also undergone distal clavicle resection and acromioplasty with rotator cuff repair. The claimant does not meet the ODG criteria. Therefore, the request for Left Shoulder Arthroscopy/Surgery (Diagnostic Arthroscopy with Acromioplasty, Distal Clavicle Resection, Extensive Debridement, Lysis of Adhesions Possible Revision Rotator Cuff Repair, and Indicated Procedures #29827, 29826, 29824, 29823, 29825, 29821, 29820) and DME Supply or Accessory, NOS (Purchase of Abduction Pillow Sling and Rental of a Cryotherapy Unit is not medically necessary.

ODG:

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) For average hospital LOS if criteria are met, see Hospital length of stay (LOS).
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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)
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<p>Partial claviclectomy (Mumford procedure)</p>	<p>See Surgery for shoulder dislocation for more information and references.</p> <p>ODG Indications for Surgery™ -- Partial claviclectomy: 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 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.</p>
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<p>Surgery for rotator cuff repair</p>	<p>ODG Indications for Surgery™ -- Rotator cuff repair: Criteria for rotator cuff repair with diagnosis of <u>full thickness</u> rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:</p> <p>1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS</p> <p>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</p> <p>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.</p> <p>Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of <u>partial thickness</u> rotator cuff repair OR 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 (Tenderness over the greater tuberosity is common in acute cases.) 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 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 deficit in rotator cuff.</p> <p>(Washington, 2002)</p> <p>For average hospital LOS if criteria are met, see Hospital length of stay (LOS).</p>
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<p>Postoperative abduction pillow sling</p>	<p>Recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs.</p> <p>(Ticker, 2008)</p>
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<p>Cryotherapy</p>	<p>See Cold packs; Continuous-flow cryotherapy; & Ice packs.</p>
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Cold packs	Recommended. See other body-part chapters for references.
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Continuous-flow cryotherapy	Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e, frostbite) are extremely rare but can be devastating. (Hubbard, 2004) (Osahr, 2002) (Singh, 2001) See the Knee Chapter for more information and references.
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Ice packs	See Cold packs .
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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)