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Date notice sent to all parties: 07/16/18

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left shoulder arthroscopic decompression and debridement with distal clavicle excision

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

Board Certified in Orthopedic Surgery Diplomate of the American Board of Orthopedic Surgery

Fellow of the American Academy of Orthopedic Surgeons

Fellow of the American Associates of Orthopedic Surgeons

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be: **X** 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 <u>each</u> of the health care services in dispute.

Left shoulder arthroscopic decompression and debridement with distal clavicle excision – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

XX examined the patient for XX left shoulder on XXXX. XX had reduced left shoulder strength and painful range of motion. Impingement testing was positive. X-rays noted AC joint arthritis and a type II acromion. A left shoulder MRI was recommended and then performed on XX It revealed moderate active AC arthropathy and mild rotator cuff peritendinitis and tendinosis without microtear. There was mild glenohumeral arthropathy and non-adhesive capsulitis. Slight labral blunting and fraying without discreet tear or paralabral cyst was noted. The patient then returned to XX on XX. Arthroscopic subacromial decompression and distal clavicle excision was recommended. On XX the patient informed XX. XX

had left shoulder pain that radiated to the neck down the left arm intermittently. On XX, XX provided an adverse determination for the requested left shoulder surgery. The patient was then initially evaluated in therapy on XX. Flexion was 92 degrees, abduction was 65 degrees, external rotation was 51 degrees, and internal rotation was 52 degrees. Therapy was recommended 2-3 times a week for 6 weeks. On Xx, XX performed a left shoulder XX injection and XX had not had therapy scheduled yet. On XX and XX, XX provided notices of adverse determination for the requested physical therapy. The patient then followed-up with XX on XX. It was felt XX had failed conservative treatment and arthroscopic decompression and distal clavicle excision were recommended, which XX provided adverse determinations for on XX and XX.

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

The patient is a XX and the first medical is dated XX and was an office visit from XX in which the patient reported that XX had spontaneously developed left shoulder pain two weeks previously. XX reported aching, which radiated into XX neck. Past medical history was significant for impingement syndrome of the shoulder dating back to XX, but the side was not mentioned. X-rays on that date revealed acromioclavicular arthritis and a type 2 acromion. Subsequent MRI scan documented moderate acromioclavicular arthrosis, tendinitis and tendinosis, but no full thickness rotator cuff tears, and mild glenohumeral arthrosis. XX recommended surgery, despite inconsistencies in mechanism of injury and range of motion parameters. The request was denied on initial review by XX M.D. XX non-certification was upheld on reconsideration/appeal by XX, M.D. on XX. Both reviewers attempted peer-to-peer without success and based their opinions on criteria outlined by the evidence-based <u>Official Disability Guidelines (ODG</u>).

The <u>ODG</u> notes that surgery for impingement syndrome is not recommended as an isolated procedure since best evidence regarding long-term clinical outcomes for surgery has consistently been no better than conservative treatment for subacromial impingement syndrome, rotator cuff tendinopathy, or in association with rotator cuff tears. While subacromial decompression has been historically encouraged, 20-30% long-term failure rates have been recently reported, being especially poor for Workers' Compensation patients. When preauthorization is considered beyond these guidelines based on specific individual patient consideration, especially with other treatable shoulder pathology, then simple bursectomy/debridement is currently favored over acromioplasty. The ODG indication for surgery, bursectomy/debridement and/or acromioplasty, criteria for subacromial decompression for subacromial impingement syndrome (80% improved without surgery), is not recommended as an isolated procedure. 1) Conservative care: Recommend at least one year, unless meets earlier surgical criteria for other associated shoulder diagnoses. Physical therapy combined with home exercises, non-steroidals, corticosteroid injection, and taping are beneficial. Treatment must be directed toward gaining full motion with stretching and strengthening to re-balance shoulder musculature; plus, 2) subjective clinical findings: Significant functional impairment persisting at least one year and pain

with active arc motion between 90-130 degrees and pain at night; plus, 3) objective clinical findings: Tenderness over rotator cuff or anterior acromion 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 MRI scan, ultrasound, or arthrogram shows positive evidence of impingement, subacromial bursitis, rotator cuff tendinosis, type 2 or type 3 acromion. Risk versus benefit: Surgery for subacromial impingement syndrome has gradually fallen out of favor over the past decade due to questionable efficacy and higher than previously understood failure rates. Acromioplasty offers no additional benefit during rotator cuff repair, adding potential increased morbidity. Pain reduction has not been significantly reduced following surgery for subacromial impingement syndrome, and over half fail to regain normal shoulder function or active range of motion. Failure of isolated subacromial decompression occurs in 21-29% with poor outcomes being even higher for Workers' Compensation patients, calcific tendinitis, deep partial thickness rotator cuff tears, and with clavicular coplaning. Since multiple systemic reviews and meta-analysis have demonstrated equivalent results with or without surgery for subacromial impingement syndrome, risk generally exceeds benefit for surgical treatment. In addition, the ODG indications for surgery, partial clavicectomy, include the following: Criteria for partial clavicectomy include muscle procedure with diagnosis of posttraumatic arthritis of the acromioclavicular joint. 1) Conservative care: At least six weeks of care directed towards symptom relief prior to surgery. Surgery is not indicated before six weeks; plus, 2) subjective clinical findings: Pain at AC joint, aggravation of pain with shoulder motion or carrying weight, or previous grade 1 or grade 2 AC separation; plus, 3) objective clinical findings to include tenderness over the acromioclavicular (most symptomatic patients with partial AC joint separate have a positive bone scan) and/or relief of pain with injection of anesthetic for diagnostic and therapeutic trial; plus, 4) imaging/clinical findings to include conventional films showing either posttraumatic changes of the AC joint or severe degenerative joint disease of the AC joint or complete or incomplete separation of the AC joint and bone scan is positive for AC joint separation.

Based on the documentation review, the patient has not failed an adequate trial of conservative treatment to include activity modification, non-steroidal antiinflammatories, steroid injection, and an active trial of physical therapy. Physical therapy has been denied because the request has exceeded the number of visits as recommended by the <u>ODG</u>. The patient has had a steroid injection, but reported no benefit, which is inconsistent with the diagnosis. Range of motion, as documented by the therapist on the one-time evaluation, is not consistent with the diagnosis, as well. The request, therefore, is not consistent with the <u>ODG</u> criteria. The diagnosis, based upon the lack of range of motion by the therapist,

is not consistent with impingement syndrome, but a component of adhesive capsulitis. In addition, the patient has reported different timing of injury to various providers. Therefore, the requested left shoulder arthroscopic decompression and distal clavicle resection are not medically necessary, appropriate, or supported by the evidence based <u>ODG</u> and the previous adverse determinations should be upheld at this time.

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
- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

- X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

PEER REVIEWED NATIONALLY	ACCEPTED	MEDICAL	LITERATURE
(PROVIDE A DESCRIPTION)			

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)