MEDICAL EVALUATORS
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DATE OF REVIEW: May 21, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Denial of left shoulder arthroscopic, acromioplasty, debridement biceps tenodesis w/ sx assist (CPT 29826, 29823, 29828)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
This case was reviewed by a physician who holds a board certification in Orthopedic Surgery who is currently licensed and practicing in the State of Texas.

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

☒ Upheld

EMPLOYEE CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who was injured on XXXX when XXXX. When XXXX. XXXX left arm was XXXX wrist and leg. The claimant has been previously treated with medications (XX and XX), 2 injections, modified duty, rest, ice and physical therapy.

Progress note by XXXX dated XXXX documented the claimant complained of left shoulder pain. The claimant described the pain as sharp, aching, without distal radiation and with distal numbness or tingling of moderate intensity and was located in the generalized entire part of the shoulder. The claimant reported the symptoms were more severe with reaching overhead, reaching back, reaching forward, lifting, pulling, pushing and sleeping at night. The MRI of the left shoulder obtained XXXX revealed no high-grade or full-thickness retractile rotator cuff tendon tear, mild supraspinatus and infraspinatus tendinosis, mild subscapularis tendinopathy with small intrasubstance longitudinal partial tearing along the superior fascicle including its insertion, bifid proximal long head biceps with mild tendinopathy of the intra-articular segment without tear, retraction or dislocation. The physical exam of the left upper extremity revealed no swelling or deformities, tender at bicipital groove, mildly limited in all planes, worse with elevation and abduction, no crepitation. Strength 5/5 forward elevation, internal rotation, external rotation, adduction and abduction but limited with pain. There was positive Neer's and positive Hawkins tests. The muscle tone was normal, no atrophy, and sensation intact to light touch. The AP and lateral views of left shoulder humerus revealed no soft tissue abnormalities, alignment was normal, no fractures, normal appearing joint spaces, normal bone density, no bony lesions, acromion type II variant with lateral downsloping. The assessment was impingement syndrome of left shoulder, tendinitis of left rotator cuff, and biceps tendinitis of left upper extremity. The provider recommended eft shoulder arthroscopic, acromioplasty, debridement biceps tenodesis for treatment of the claimant's condition.

Prior UR letter dated XXXX denied the request for coverage of left shoulder arthroscopic acromioplasty, debridement biceps tenodesis w/ sx assist (CPT 29826, 29823, 29828) because there is no documentation of failed conservative care of at least one year. There is also no documentation of significant functional impairment persisting at least 1 year or pain with active motion between 90-130 degrees.

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

The claimant is a XXXX who injured XXXX left shoulder on XXXX and diagnosed with impingement syndrome of left shoulder, tendinitis of left rotator cuff, and biceps tendinitis of left upper extremity. The request is for coverage of left shoulder arthroscopic acromioplasty, debridement biceps tenodesis w/ sx assist (CPT 29826, 29823, 29828).

As per the Official Disability Guidelines (ODG), the criteria for subacromial decompression for subacromial impingement syndrome requires trial and failure of at least 1 year of conservative treatment unless meets earlier surgical criteria for other associated shoulder diagnoses, significant functional impairment persisting at least 1 year and pain with active arc motion between 90-130 degrees, tenderness over rotator cuff or anterior acromial area, positive impingement signs, temporary relief of pain with anesthetic injection (diagnostic injection test), and clinical findings (x-rays, MRI, ultrasound, or arthrogram shows positive evidence of impingement (subacromial bursitis, rotator cuff tendinosis, Type II or III acromion). In this case, the claimant does not meet all the above ODG criteria for the requested surgical procedure. There is no evidence that the claimant failed conservative care of at least one year and no documentation of significant functional impairment persisting at least 1 year. The most recent progress note dated XXXX documented mildly limited left shoulder range of motion in all planes, worse with elevation and abduction but no documentation of pain with active motion between 90-130 degrees. Since the medical necessity of the requested left shoulder surgery is not established, the request for surgical assistant is also considered not medically necessary.

Therefore, based on the ODG as well as the clinical documentation stated above, the request for coverage of left shoulder arthroscopic, acromioplasty, debridement biceps tenodesis w/ sx assist (CPT 29826, 29823, 29828) is not medically necessary and appropriate at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

Official Disability Guidelines (Online Version)
Shoulder (Acute & Chronic) (updated 05/09/2018)
Surgery for impingement syndrome