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## **Notice of Independent Review Decision**

**Date notice sent to all parties:**

April 29, 2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Arthroscopy RT Shoulder/Rotator Cuff Repair / Biceps  
Tenodesis/Acromioplasty

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

Board Certified Orthopedic Surgeon

**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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

Clinical notes by Dr. dated 10/15/12 – 02/18/13  
Electrodiagnostic studies dated 01/23/13  
Clinical report by Dr. dated 01/23/13  
MRI of the right shoulder dated 02/06/13  
Legal document dated 04/12/13  
Prior reviews dated 03/04/13 & 03/22/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained an injury on xx/xx/xx. The patient was seen by Dr. with complaints of right knee pain after she was pushed down by a student. The patient also reported pain in the right shoulder as well as numbness in the right foot. The initial physical examination of the shoulder demonstrated full range of motion with bruising noted in the right proximal arm. The patient was initially assessed with a right interior cruciate ligament tear which was recommended by Dr. to be treated conservatively. The patient is noted to be status post right knee arthroscopy with debridement of the anterior cruciate ligament with partial medial meniscectomy performed on 11/14/12. Electrodiagnostic studies performed on 01/23/13 were reported to be consistent with a tarsal tunnel syndrome in the right lower extremity. The patient was seen by Dr. on 01/30/13 with complaints of ongoing right foot pain as well as right shoulder pain. Physical examination again reported full range of motion in the right shoulder. MRI studies were recommended and performed on 02/06/13. There was evidence of a tear in the supraspinatus tendon with no evidence of retraction or atrophy. The biceps tendon appeared normal. No evidence of labral tearing was seen and there was a small amount of bursa fluid present. Follow up on 02/18/13 with Dr. reported no changes on physical examination for the right shoulder. The patient was recommended for a right shoulder arthroscopic rotator cuff repair with possible biceps tenodesis and acromioplasty.

The request for a right shoulder arthroscopy with rotator cuff repair biceps tenodesis and acromioplasty was denied by a utilization review on 03/04/13 as there was no documentation regarding non-operative conservative treatments.

The request was again denied by a utilization review on 03/22/13 as there was no updated right shoulder exam to assess current deficits. There was no imaging evidence of biceps pathology and no documentation regarding a reasonable course of conservative treatment.

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

From the clinical documentation, the patient was initially assessed with a right knee

ACL tear which eventually underwent surgical repair. Postoperatively the patient reported ongoing complaints of right shoulder pain, however, the patient's exam findings for the right shoulder are very limited. Most of the evaluations indicate that the exam findings are unchanged and given the patient originally had no range of motion deficits or any other positive orthopedic findings to suggest a symptomatic rotator cuff tear, there are overall limited objective findings to support any surgical requests. Based on the imaging studies it is unclear whether a whole thickness tear in the rotator cuff is present. The study did not identify any significant retraction or atrophy of the rotator cuff. The biceps tendon appeared normal and there was no apparent impingement of the subacromial outlet. Additionally, the clinical documentation does not establish any conservative treatment for the right shoulder. There is no indication that the patient failed to improve with a conservative treatment program including physical therapy, use of anti-inflammatories, or subacromial injection as recommended by current evidence based guidelines. Given the lack of clinical evidence to support the surgical procedures as well as lack of documentation regarding conservative treatments, it is this reviewer's opinion that medical necessity for the request is not established.

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

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Official Disability Guidelines, Online Version, Shoulder Chapter  
**ODG Indications for Surgery<sup>TM</sup> -- 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:  
**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.

(Washington, 2002)

**ODG Indications for Surgery™ -- Ruptured biceps tendon surgery:**

**Criteria** for tenodesis of long head of biceps (Consideration of tenodesis should include the following: Patient should be a young adult; not recommended as an independent stand alone procedure. There must be evidence of an incomplete tear.) with diagnosis of incomplete tear or fraying of the proximal biceps tendon (The diagnosis of fraying is usually identified at the time of acromioplasty or rotator cuff repair so may require retrospective review.):

**1. Subjective Clinical Findings:** Complaint of more than "normal" amount of pain that does not resolve with attempt to use arm. Pain and function fails to follow normal course of recovery. PLUS

**2. Objective Clinical Findings:** Partial thickness tears do not have classical appearance of ruptured muscle. PLUS

**3. Imaging Clinical Findings:** Same as that required to rule out full thickness rotator cuff tear: Conventional x-rays, AP and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.