Claims Eval

Notice of Independent Review Decision

May 14, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient Surgery - Right shoulder EUA, Diagnostic arthroscopy w/ debridement, SAD, Mumford, Rotator cuff/slap repair to include CPT codes 23120, 23412, 29822, 29823, 29824, 29825, 29826, 29807.

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

American Board of Orthopaedic Surgery

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

Employer's First Report of Injury dated xx/xx/xx notes the claimant was pulling tables. She felt sharp pain on right chest when moving the table.

11-6-12, the claimant presents for accidentally hurt right shoulder. The claimant felt a sharp "tug" at the shoulder initially, relieved at rest and pain recurred yesterday when she returned to work. 5/10 at rest, worse on overhead activities, and lying on right side. Upper extremity exam: Shoulder (Right, active ROM able to abduct 90 deg. and forward, flexion 110 deg, not able to reach back of head, able to reach lower back with some discomfort. passive abduction >170deg. decreased grip strength, tenderness noted on lat acromion and at the coracoid process anteriorly. Plan: Lortab 5/500, Duexis, physical therapy ordered.

11-8-12 Physical therapy initial evaluation.

Physical therapy on 11-8-12, 11-12-12, 11-15-12, 11-19-12, 11-21-12, 11-27-12, 11-29-12, 12-6-12, 12-10-12, 12-13-12, 12-18-12, 12-20-12, and 12-31-12.

11-20-12, the claimant presents for c/o burning sensation on Rt. deltoid radiating distally, and on back of shoulder as well, on overhead and reaching out activities. States PT/ has helped somewhat in ROM, but pain still present. She is doing light duty for now. The evaluator performed a shoulder injection into the right posterior glenohumeral joint. He recommended an MRI of the right shoulder. The claimant is to continue with physical therapy and light duty.

12-3-12, the claimant reports she is able to move better than last time, but complains of pain after physical therapy/range of motion exercises. She is on light duty. MRI scheduled for later this week. Plan: Will obtain MRI, the claimant is to continue light duty and NSAIDS for now.

12-7-12 MRI of the right shoulder shows two small tears within the supraspinatus tendon, no disruption. Supraspinatus tendinitis. Impingement anatomy secondary to hypertrophy of the acromioclavicular articulation and down sloping of the acromion.

12-17-12, the claimant is seen for followup. The claimant presents for Rt. shoulder pain. She is doing PT/ROM exercises, and restricted work. Takes ibuprofen, had an MRI recently, states pain worse on overhead activities, no tingling or numbness. The claimant was provided with Ibuprofen 800 mg, referral to ortho for right rotator cuff disorder. The claimant is to continue light duty.

2-18-13, the claimant presents for pain improved from last visit, not doing PT/ROM exercises at present. She states pain is better, although still hurts and a 'burning sensation' on outside of Rt upper arm and front of shoulder on abduction and overhead reaching. She is doing light duty and has appointment next week. The claimant is to followup in a month. She is to use NSAIDs as needed, rest, and avoid overhead activities.

3-8-13, the claimant is a right-hand dominant female here to see for the first time. She has had a history of right shoulder pain since sustaining a work-related injury in November 2012. At that time, she heard a pop and a click in her right shoulder and had immediate pain and decreased range of motion. She has already undergone 11 weeks of physical therapy and was evaluated who has requested this consultation evaluation. After he evaluated her, she received at least two steroid joint injections, which brought her minimal pain relief. She did not improve much with her 11 weeks of physical therapy either. She has tried Hydrocodone and over-the-counter anti-inflammatories as well as prescription strength ibuprofen and none of these results in adequate pain relief. Given the amount of time that she has tried nonoperative therapy, has requested presurgical evaluation in which case the surgery might help improve her pain on a regular basis. Her pain is a 7/10 and she has been put on light duty at work, but still experiences pain during her working duty hours. She denies any numbness or tingling or any other neuropathic symptoms on the right arm. On exam, she has tenderness to palpation over the AC joint as well as anteriorly over the subscap and supraspinatus areas of the shoulder. She has 5/5 grip strength. AIN, PIN, and hand intrinsics are intact. Sensation is intact to light touch distally. 2+ distal pulses. Brisk capillary refill to all digits. She has forward

flexion to 90 degrees without pain and forward elevation passively to 180 degrees. She is able to initiate abduction. She has positive O'Brien test and positive impingement with crossover. Assessment and plan: The patient is a right-hand dominant female who sustained a work-related injury and after that time, she continued to have right shoulder pain despite adequate physical therapy and steroid injections as well as use of over-the-counter prescription pain medication. She has been sent to us for evaluation and they have extensively discussed continued nonoperative treatment versus operative intervention. The patient has opted to proceed with operative intervention at this time and she wishes to explore further operative options. The evaluator will apply for approval for surgery from Workers Compensation and the evaluator will have the patient follow up in clinic after this is approved for further details about her surgery. The patient verbalizes good understanding of treatment and followup plan.

3-11-13 X-rays of the right shoulder shows no acute post traumatic bony abnormality of the shoulder. Calcific rotator cuff tendinopathy suggested.

3-14-13, performed a Peer to Peer Review. The records indicate 2 small tears in the supraspinatus tendon with hypertrophy of the AC joint producing mild impingement. No labral tears were noted. Active forward flexion was only 90 degrees and no specific weakness was noted. The records indicated a posterior glenohumeral joint injection on 11/20/12 and abduction did not improve much following injection. The reviewer did not see documentation of a subacromial or AC joint injection and the MRI does not indicate whether or not the small tears are full thickness. The symptoms of pain 7/10 and limited forward flexion seem out of proportion to the MRI findings. Under these circumstances, the requests would not meet Guideline criteria and the request should not be certified.

3-21-13, performed a Peer Review. Call placed at 1045 CDT 21 Mar 13 and again at 1500 CDT 21 Mar 13. Unable to reach anyone through the clinic phone to discuss the case on either attempt. The current request is for shoulder examination under anesthesia with arthroscopic debridement and rotator cuff / SLAP repair. This individual had a pulling injury 11/12 during the course of her employment and failed to respond to PT and injections. MRI documents minimal rotator cuff pathology and moderate impingement appropriate for her age. The requested procedures do not correspond with the pathology on the MRI. Recommend denial.

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

The reported mechanism of injury of lifting tables is vague and not likely to cause an injury to the rotator cuff.

The claimant has received appropriate care with PT and a posterior shoulder injection. The medical record does not document a subacrominal injection or an injection of the AC joint.

The treating physicians document a lack of improvement with physical therapy, medication and time. Their conclusion that the next form of treatment should be surgery to see if this will reduce the shoulder pain is not logical or scientific. The exam findings do not have a high level of accuracy based on sensitivity and specificity.

The MRI studies of the shoulder reveal likely degenerative changes of the rotator cuff consistent for the claimant's age. The MRI noted two small tears but no disruption.

Based on the medical documentation, there is no indication for surgical treatment of the Right Shoulder. Therefore, the request for Outpatient Surgery - Right shoulder EUA, Diagnostic arthroscopy w/ debridement, SAD, Mumford, Rotator cuff/slap repair to include CPT codes 23120, 23412, 29822, 29823, 29824, 29825, 29826, 29807 is not reasonable or medically indicated.

Per ODG 2013 Surgery for rotator cuff tear: Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, but the outcomes from open repair are as good or better. Surgery is not indicated for patients with mild symptoms or those who have no limitations of activities. (Ejnisman-Cochrane, 2004) (Grant, 2004) Lesions of the rotator cuff are best thought of as a continuum, from mild inflammation and degeneration to full avulsions. Studies of normal subjects document the universal presence of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment but without surgical risks. Studies evaluating results of conservative treatment of full-thickness rotator cuff tears have shown an 82-86% success rate for patients presenting within three months of injury. The efficacy of arthroscopic decompression for full-thickness tears depends on the size of the tear; one study reported satisfactory results in 90% of patients with small tears. A prior study by the same group reported satisfactory results in 86% of patients who underwent open repair for larger tears. Surgical outcomes are much better in younger patients with a rotator cuff tear, than in older patients, who may be suffering from degenerative changes in the rotator cuff. Referral for surgical consultation may be indicated for patients who have: Activity limitation for more than three months, plus existence of a surgical lesion; Failure of exercise programs to increase range of motion and strength of the musculature around the shoulder, plus existence of a surgical lesion; Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair; Red flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.).

Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears are treated the same as impingement syndrome regardless of MRI findings. Outpatient rotator cuff repair is a well accepted and cost effective procedure. (Cordasco, 2000) Difference between surgery & exercise was not significant. (Brox, 1999) There is significant variation in surgical decision-making and a lack of clinical agreement among orthopaedic surgeons about rotator cuff surgery. (Dunn, 2005) For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopaedic referral. Patients with small tears of the rotator cuff may be referred to an orthopaedist after 6 to 12 weeks of conservative treatment. (Burbank2, 2008) Patients with workers' compensation claims have worse outcomes after rotator cuff repair. (Henn, 2008)

Revision rotator cuff repair: The results of revision rotator cuff repair are inferior to those of primary repair. While pain relief may be achieved in most patients, selection criteria should include patients with an intact deltoid origin, good-quality rotator cuff tissue, preoperative elevation above the horizontal, and only one prior procedure. (Djurasovic, 2001)

Recent research: Evidence on the pros and cons of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive, an AHRQ comparative effectiveness review concluded. While the data are sparse, patients improved substantially with all interventions; there were few clinically important differences between approaches, and complications were rare. Most patients try to resolve their pain and disability with a course of physical therapy before attempting surgery, but the study found very little good quality research to guide the choice of nonoperative treatment, the timing of treatment, and who would most benefit from various forms of treatment. Four out of five studies comparing surgical and nonsurgical management favored operative repair, but the evidence was too limited to make conclusions regarding comparative effectiveness. 113 studies comparing various operations found no differences in functional outcomes between open vs mini-open repair, mini-open vs arthroscopic repair, arthroscopic repairs with vs without acromioplasty, and single-row vs double-row fixation. Patients who had mini-open repair returned to work about a month earlier than patients who had open repair. On the other hand, functional improvement was better after open repair compared with arthroscopic debridement. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain. One study found no difference in range of motion or strength, while another suggested that adding continuous passive motion shortened the time until return to work and the time to 90 degrees abduction. For other postoperative rehabilitation strategies, one study showed that progressive loading reduced pain compared to traditional loading. In general, though, most studies found no difference in health-related quality of life, function, pain, range of motion, and strength with one approach versus another (e.g., with or without aquatics, individualized vs at home alone, videotape vs therapist-based, etc.). In the 72 studies that assessed prognostic factors, older age, increasing tear size, and greater preoperative symptoms were consistently associated with recurrent tears, whereas gender, workers’ compensation status, and duration of symptoms usually

did not predict poorer outcomes. (Seida, 2010) "Rotator cuff surgery is a viable option for many patients, but, as with any surgery, it is not for everybody," said AHRQ Director Carolyn M. Clancy, M.D. "This report has good news: most interventions work, and each patient should talk to his or her doctor about which to option to pursue." Most older patients who suffer a rotator cuff tear are first treated with up to 3 months of nonsurgical treatment such as pain and anti-inflammatory medications, exercise, and rest. If treatments other than surgery do not work, the rotator cuff may be repaired surgically, using a variety of methods ranging from minimally invasive techniques to an open operation. Patients can then undergo rehabilitation to restore their range of motion, muscle strength, and function following surgery. Rotator cuff tears also can occur in younger adults, usually as a result of traumatic injury. In such cases they are almost always treated with surgery. Some doctors have maintained that earlier surgery results in less pain and better use of the shoulder, leading to an earlier return to work and decreased costs; so, patients often face the difficult decision of opting for surgery rather than waiting for nonoperative treatments to work. However, researchers found little evidence that earlier surgery benefits patients. Comparative Effectiveness of Nonoperative and Operative Treatments for Rotator Cuff Tears is the newest comparative effectiveness report from the AHRQ's Effective Health Care Program. The Effective Health Care Program represents the leading federal effort to compare alternative treatments for health conditions and make the findings public, to help doctors, nurses, pharmacists and others work together with patients to choose the most effective treatments. (Clancy, 2010) This prospective cohort study concluded that PT is effective for most patients with atraumatic full-thickness rotator cuff tears and shoulder pain, without the need for surgery. At six weeks fewer than 10% of patients had decided to undergo surgery, and after 2 years, only 2% of the rest had opted for surgery. Patients did most of their physical therapy at home and usually made only 1 weekly visit to the physical therapist. (Kuhn, 2011) One-third of rotator cuff repairs fail, and 74% of the failures occur within three months of surgery. Healed tendons, or recurrent tears, at six months can predict outcomes at seven years. (Kluger, 2011) Not surprisingly, larger tears are harder to repair, and the retear rate based on rotator cuff tear size is: 10% for ≤2 cm2; 16% for 2–4 cm2; 31% for 4–6 cm2; 50% for 6–8 cm2; & 57% for >8 cm2. (Murrell, 2012) There is insufficient evidence to suggest efficacy in operative or nonoperative treatment of rotator cuff tears in in patients aged older than 60 years. (Downie, 2012)

ODG Indications for Surgery -- 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:
1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS
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
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.

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)
For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

Per ODG Surgery for SLAP lesions: Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. The advent of shoulder arthroscopy, as well as our improved understanding of shoulder anatomy and biomechanics, has led to the identification of previously undiagnosed lesions involving the superior labrum and biceps tendon anchor. Although the history and physical examinations as well as improved imaging modalities (arthro-MRI, arthro-CT) are extremely important in understanding the pathology, the definitive diagnosis of superior labrum anterior to posterior (SLAP) lesions is accomplished through diagnostic arthroscopy. Treatment of these lesions is directed according to the type of SLAP lesion. Generally, type I and type III lesions did not need any treatment or are debrided, whereas type II and many type IV lesions are repaired. (Nam, 2003) (Pujol, 2006) (Wheeless, 2007) Shoulder surgery for SLAP tears may not be successful for many patients. For example, of pitchers who failed physical rehabilitation and then went on to surgery just 7% were able to play as well as they had before, but for pitchers who just underwent physical rehabilitation, 22% were able to play as well as they previously had. (Fedoriw, 2012)

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)**