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Notice of Independent Review Decision

June 3, 2014

**IRO CASE #:**

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

Right diagnostic shoulder arthroscopy with subacromial decompression possible rotator cuff repair, SLAP repair, proximal tenotomy with or without tenodesis, extensive debridement and synovectomy.

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

Orthopedic Physician

**REVIEW OUTCOME:**

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

Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

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

This is a gentleman who was injured on xx/xx/xx noting right shoulder pain. This was a traction type injury that can result in a SLAP type of tear. He has had physical therapy, medicines, work restrictions and injections in the joint, which provided transient relief. An unenhanced MRI did not demonstrate any significant full, but had a partial tear, proximal biceps tenosynovitis. Given the appropriate nonsurgical care, correlating appropriate subjective complaints and objective findings, it is reasonable at this present time to proceed with diagnostic, arthroscopic shoulder surgery, acromioplasty, possible rotator cuff and SLAP repair versus tenodesis of the biceps. Based on review of the medical records provided, it appears to be indicated to proceed with surgery as requested.

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

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who on xx/xx/xx, strained his right shoulder. He had instant pain but did not think much of it until he realized the pain was not going away and he had decreased movement of right arm/shoulder.

On xx/xx/xx, evaluated the patient for right shoulder complaints. It was noted that following the injury, the patient had instant pain but he did not think much of it until he realized the pain was not going away and he had decreased movement of right arm/shoulder. Examination of the right shoulder showed decreased flexion to 150 degrees, abduction to 105 degrees and internal rotation to the level of posterior hip. There was pain at the end limits of range of motion testing. Testing revealed equivocal signs of impingement. There was positive Apley's scratch test. Palpation of shoulder demonstrated moderate tenderness at the acromioclavicular joint and biceps tendon. diagnosed shoulder strain, prescribed ibuprofen and Flexeril and recommended starting a structured physical therapy program.

On January 13, 2014, evaluated the patient for ongoing complaints. The patient felt that the pattern of symptoms was unchanged. recommended continuing current medications and continuing physical therapy.

From January 15, 2014, through March 4, 2014, the patient attended 12 sessions of physical therapy consisting of therapeutic activities and manual therapy.

On January 27, 2014, noted the pattern of symptoms was unchanged. He diagnosed right shoulder strain and possible right internal derangement and prescribed ibuprofen, Flexeril and Norco. He recommended continuing physical therapy.

On January 30, 2014, recommended continuing current medication and referred the patient for magnetic resonance imaging (MRI) of the right shoulder for evaluation of possible rotator cuff tear.

On February 10, 2014, MRI of the right shoulder showed a small area of interstitial tear involving the distal infraspinatus tendon without bursal or articular surface extension. There was subacromial/subdeltoid bursitis.

On February 14, 2014, noted that the pattern of symptoms was unchanged. The patient had not been working as there was no light duty available. The patient had therapy sessions and had plateau and was not progressing. The patient complained of mild-to-moderate pain on anterior aspect of the right shoulder. reviewed the MRI findings and diagnosed right shoulder strain, small area of interstitial tear involving the distal infraspinatus tendon and subacromial/subdeltoid bursitis. He recommended continuing current medication and physical therapy. The patient was referred to an orthopedic surgeon for further evaluation and treatment.

On February 27, 2014, an orthopedic surgeon, evaluated the patient for persistent right shoulder pain. Examination of the right shoulder showed good active and

passive range of motion, but the patient had a pain at the end range. External rotation and overhead elevation caused a sharp pain in the shoulder. Speed and O'Brien tests were equivocally positive. Hawkins' was grossly positive for pain and weakness relatively equally. Proximal biceps tendon was very tender. Acromioclavicular joint was mildly tender. The subscapularis tendon anteriorly was exquisitely tender. reviewed the MRI findings and diagnosed focal partial-thickness rotator cuff tear, subscapularis; proximal biceps tendinitis, likely related to focal partial-thickness rotator cuff tear, subscapularis; focal interstitial distal supraspinatus tendon tear, possible superior labrum anterior posterior (SLAP) lesion and secondary impingement syndrome. performed injection Kenalog into the right subacromial space without complications. Hawkins' improved immediately and Speed's and O'Brien seemed less positive following the injection. Therefore, that might be mostly an impingement process possibly related to the partial subscapularis and interstitial supraspinatus tendon tears. The patient was switched from ibuprofen to long-acting Lodine XL and was recommended continuing more therapy following the injection.

On February 28, 2014, noted that the pattern of symptoms was stable. He recommended continuing current medications and physical therapy.

On March 21, 2014, noted the pattern of symptoms was unchanged. The patient had not been working because there was no light duty available. The patient had 12 sessions of physical therapy and had plateaued and was not progressing. He had a right shoulder cortisone injection which did not help him. Examination of the right shoulder showed tenderness of the anterior aspect of the shoulder, decreased active range of motion with pain, moderate pain with supraspinatus testing, slight pain with Speed's test and slight pain with Hawkins' impingement. prescribed tramadol and cyclobenzaprine and recommended holding physical therapy until further advise. The patient was to follow up the following week. The patient was maintained on restricted duty.

On March 27, 2014, evaluated the patient for persistent right shoulder pain. The patient continued to have anterior pain that radiated from the front of the back deep through the shoulder joint as well as writhing lateral pain. The patient was having worsening night pain making it difficult for him to sleep. Examination of the right shoulder showed good active and passive range of motion, but actively the patient had pain with forward elevation and abduction as well as crossing of the chest. External rotation and overhead elevation caused a sharp pain in the anterior shoulder. Speed and O'Brien test were really markedly positive. There was positive dynamic labral shear test as described by O'Driscoll's. Hawkins' was grossly positive for pain and weakness. Proximal biceps tendon was quite tender which was quite consistent with a positive dynamic labral shear test as well. Acromioclavicular joint was only mildly tender. Subscapularis tendon anteriorly was exquisitely tender at the lesser tubercle. revisited the right shoulder non-arthrogram MRI and recommended proceeding with right diagnostic shoulder arthroscopy/subacromial decompression with possible rotator cuff repair and possible SLAP tear, possible proximal biceps tenotomy with or without tenodesis,

extensive debridement, synovectomy and treatment as indicated. The patient had not improved despite sufficient conservative management.

Per utilization review dated April 9, 2014; the request for right diagnostic shoulder arthroscopy with subacromial decompression possible rotator cuff repair, SLAP repair, proximal tenotomy with or without tenodesis, extensive debridement and synovectomy was denied based on the following rationale: *“The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The mechanism of injury was when he felt intense pain in his right shoulder. Medications for the last 60 days were not provided. Surgical history was not listed. Diagnostic studies were only stated as the patient having undergone an MRI of the right shoulder performed on February 10, 2014. Other therapies were listed as 12 sessions of physical therapy for the right shoulder and a cortisone injection to the right shoulder performed on February 27, 2014. The patient is a male who reported an injury on xx/xx/xx. The patient was reportedly injured when he subsequently strained his right shoulder. The patient underwent an MRI of the right shoulder on February 10, 2014, which noted a small area of interstitial tear involving the distal infraspinatus tendon without bursal or articular surface extension. The remainder of the rotator cuff was intact, with subacromial/subdeltoid bursitis noted and an intact labrum and biceps tendon. The patient was seen again on March 21, 2014, after having completed approximately 12 sessions of physical therapy. At the time of the exam, the patient had been unable to work due to no light duty jobs available. The patient had undergone a previous cortisone injection to the right shoulder, which did not help. The patient was most recently seen on March 27, 2014 whereupon the patient stated that the pain is anterior which radiates from the front to the back deep through the shoulder joint as well as writhing lateral pain. The patient is having worsening nighttime pain making it difficult for him to sleep. On the examination, external rotation and overhead elevation caused a sharp pain in the anterior shoulder, with Speed's and O'Brien's tests markedly positive. The patient had a positive DLST as described by O'Driscoll's, with Hawkins grossly positive for pain and weakness. The patient had no instability, with the proximal biceps tendon quite tender which is consistent with the positive DLST, and the AC joint was only mildly tender. The subscapularis tendon anteriorly was exquisitely tender at the lesser tubercle; however, no distal swelling was noted. The physician stated that he revisited the right shoulder non-arthrogram MRI, which noted evidence of a partial tear of the superior one-third of the subscapularis tendon which would also be very consistent with a possible SLAP lesion as these two lesions occur frequently together, but there was also quite a bit of interstitial signal change at the insertion site of the SST in the mid substance which does not really favor a focal SST tear. Regarding the request for a right diagnostic shoulder arthroscopy with subacromial decompression with possible rotator cuff repair, SLAP repair, proximal tenotomy with or without tenodesis, extensive debridement, and synovectomy, criteria for a rotator cuff repair includes the use of conventional x-rays, AP, and true lateral or axillary views to go along with an MRI. The patient has not undergone a previous plain view x-ray of the right shoulder to include AP and true lateral or axillary views. However, with the patient's signs and symptoms as well as an MRI revealing a small area of interstitial tear of the*

*distal infraspinatus tendon, and due to the patient meeting the other Guideline criteria, the patient would be considered a candidate for a rotator cuff repair for a partial tear of the supraspinatus. The patient also meets Guideline criteria for a SLAP repair to include debridement and synovectomy. However, the request for a proximal tenotomy with or without tenodesis cannot be certified, as the imaging studies do not corroborate with the clinical findings pertaining to the biceps tendon. The MRI performed on February 10, 2014 stated that the glenoid labrum is intact, with the tendon of the long head of the biceps and the biceps/labral anchor intact. The patient only recently began demonstrating tenderness to the biceps region as noted on the March 27, 2014 follow-up visit notes. However, because the patient does not meet all of the Guideline criteria for the requested services, the request in its entirety cannot be supported. As such, the request for Right Diagnostic Shoulder Arthroscopy with Subacromial Decompression possible Rotator Cuff Repair, SLAP Repair, Proximal Tenotomy with or without Tenodesis, Extensive Debridement, Synovectomy is non-certified."*

On May 5, 2014, the appeal for right diagnostic shoulder arthroscopy with subacromial decompression possible rotator cuff repair, SLAP repair, proximal tenotomy with or without tenodesis, extensive debridement and synovectomy was denied based on the following rationale: *"The patient is a male who injured his right shoulder on xx/xx/xx. He is diagnosed with rotator cuff tear/tendinosis, proximal biceps tendinitis, possible superior labrum anterior posterior lesion, and secondary impingement syndrome. An appeal request is made for right shoulder diagnostic arthroscopy with subacromial decompression possible rotator cuff repair, SLAP repair, proximal tenotomy with or without tenodesis, extensive debridement and synovectomy. The request was previously denied because, although the patient would be considered a candidate for a rotator cuff repair for a partial tear and a SLAP repair to include debridement and synovectomy, the request for a proximal tenotomy with or without tenodesis was not supported as the imaging studies did not corroborate clinical findings pertaining the biceps tendon. The patient only recently began demonstrating tenderness to the biceps region as noted on the March 27, 2014, follow-up visit note. As the patient did not meet all of the guideline criteria for the proposed procedures, the request in its entirety could not be certified. Prior treatments had consisted of activity restrictions, ice application, medications, physical therapy (12 sessions), home exercise program, and cortisone injection on February 27, 2014 which did not help. The patient had been most recently prescribed with tramadol and cyclobenzaprine. He had not been working because there was no light duty available. Right shoulder MRI dated February 10, 2014, demonstrated a small area of interstitial tear involving the distal infraspinatus tendon without bursal or articular surface extension; subacromial/subdeltoid bursitis; and intact labrum and biceps tendon. As per March 27, 2014 follow-up, he complained of persistent right shoulder pain. He continued to have anterior pain that radiated from the front to the back deep through the shoulder joint, as well as "writhing" lateral pain. He was having worsening nighttime pain, making it difficult to sleep. Examination of the right shoulder revealed good active and passive range of motion but with pain on active forward elevation, abduction and crossing of the chest; sharp pain in the anterior shoulder with external rotation and overhead elevation markedly*

*positive Speed's and O'Brien's tests; positive DLST as described by O'Driscoll's; grossly positive Hawkins for pain and weakness; no instability; quite tender proximal biceps tendon consistent with the positive DLST as well; mildly tender AC joint; exquisitely tender subscapularis tendon anteriorly at the lesser tubercle; and no distal swelling. On review of the MRI, there was evidence of a partial tear of the superior 1/3 of the subscapularis tendon which would also be very consistent with a possible SLAP lesion as these two lesions occur frequently together. There was also quite a bit of interstitial signal change at the insertion site of the SST in the mid substance which did not really favor a focal SST tear. It was stated that the patient has had a clinical plateau. Right shoulder surgery was recommended. Updated documentation included duplicates of the prior medical records submitted for review. There was no new clinical information provided that specifically addressed the previous reasons for non-certification. No recent diagnostic findings had been documented to show evidence of a biceps tendon tear that would support a proximal tenotomy with or without tenodesis. With the above issues, the medical necessity of this request remains unsubstantiated.”*

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

This is a gentleman who was injured on xx/xx/xx noting right shoulder pain. This was a traction type injury that can result in a SLAP type of tear. He has had physical therapy, medicines, work restrictions and injections in the joint, which provided transient relief. An unenhanced MRI did not demonstrate any significant full, but had a partial tear, proximal biceps tenosynovitis. Given the appropriate nonsurgical care, correlating appropriate subjective complaints and objective findings, it is reasonable at this present time to proceed with diagnostic, arthroscopic shoulder surgery, acromioplasty, possible rotator cuff and SLAP repair versus tenodesis of the biceps. Based on review of the medical records provided, it appears to be indicated to proceed with surgery as requested.

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

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