

CALIGRA MANAGEMENT, LLC
1201 ELKFORD LANE
JUSTIN, TX 76247
817-726-3015 (phone)
888-501-0299 (fax)

Notice of Independent Review Decision

September 22, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right shoulder arthroscopic shoulder capsulorrhapy, shoulder arthrodistal clavicle, shoulder arthroscopic debridement limited, medical clearance, pre-op test: CBC and brachial plexus block 29806, 29824, 29822

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:

Upheld (Agree)

Medical documentation **does not support** 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustain an injury to the right shoulder on xx/xx/xx. He developed pain at the end of the work day.

No records available from September 2013, through March 2014.

On April 22, 2014, right shoulder magnetic resonance imaging (MRI) revealed large tear of the entire posterior labrum. There was lobulated tortuous septated cyst measuring approximately 3x2 cm along the undersurface of the posterior labrum proximally and medially along the posterior neck of the glenoid process most consistent with a large paralabral cyst and less likely a ganglion cyst. There was a 4 mm interstitial tear within the anterior humeral insertion site of the supraspinatus tendon. There was mild medial subluxation and fraying of the long

head of the biceps tendon suggesting laxity and/or partial tear of the medial pulley mechanism. There was mild thickening and edema of the axillary recess involving the inferior glenohumeral ligament which could be associated with adhesive capsulitis. There was mild fraying of the superior labrum without a gross superior labrum from anterior to posterior (SLAP) tear.

On July 15, 2014, evaluated the patient for increased pain in the right shoulder with activity and with all movements associated with weakness. He was treated with physical therapy (PT) and had no change in his pain. An MRI showed large tear and cyst of posterior labrum. The patient was currently working with restrictions. There was history of asthma. He was utilizing unknown pain medications and asthma inhaler. Examination of the right shoulder revealed active range of motion (ROM) was elevation 150 degrees, external rotation 70 degrees, external rotation in abduction 80 degrees and internal rotation in abduction 70 degrees. The strength was 4/5 in supraspinatus, infraspinatus and subscapularis. There was diffuse tenderness in the acromioclavicular (AC) joint and peri-scapular area. There was positive provocative test for guarding, Speed test and O'Brien test. There was moderate left shoulder guarding and equivocal impingement. X-rays of the right shoulder showed normal GHJ, a type one/two acromion, normal/degenerative ACJ and normal AHD at 10 mm. The footprint was normal/mildly sclerotic, cystic and degenerative. MRI of the right shoulder was reviewed. diagnosed unspecified right mass/ganglion and right labral tear with instability. The patient was recommended labral repair, right shoulder DC and cyst aspiration. Norco was prescribed.

Per utilization review dated July 18, 2014, the request for right shoulder arthroscopic shoulder capsulorrhaphy, shoulder arthrodistal clavicle, shoulder arthroscopic debridement limited, medical clearance and pre-op test: CBC was denied with following rationale: *"The patient has persistent shoulder pain with elevation and reported weakness. Exam revealed positive findings of labral pathology, and the MRI revealed corroborated those. There is a large tear of the posterior labrum with a large paralabral cyst. The patient has been treated with physical therapy without improvement. In addition the provider recommends a labral repair, right shoulder DC and cyst aspiration. However, the requested procedure is for a capsulorrhaphy and ODG criteria includes history of multiple dislocations with at least one of the following: positive apprehension findings, or injury to the humeral head, or documented dislocation under anesthesia. These have not been substantiated on the medical record, and although a labral repair seems reasonable, the surgical procedure and associated surgical requests, peer to peer discussion was not achieved despite calls to office."*

On July 25, 2014, noted the patient had constant 4/10 right shoulder pain. The patient was working with restrictions. He stated that external immobilization helped the symptoms. The oral medications had no effect on the symptoms. The pain increased with activity. noted that earlier the shoulder surgery was denied and wrote a letter of medical necessity and submitted for reconsideration.

Per a letter dated July 25, 2014, requested a competent shoulder surgeon to review the request in order to proceed with the recommended shoulder surgery indicated to allow the patient to return to gainful employment.

On July 28, 2014, preauthorization/utilization review request for right shoulder arthroscopic shoulder capsulorrhaphy, shoulder arthrodistal clavicle, shoulder arthroscopic debridement limited and brachial plexus block was made.

Per reconsideration review dated August 1, 2014, the appeal for right shoulder arthroscopic shoulder capsulorrhaphy, shoulder arthrodistal clavicle, shoulder arthroscopic debridement limited, medical clearance, pre-op test: CBC and brachial plexus block was denied with the following rationale: *“The documentation indicated that the patient is complaining of right shoulder pain. A capsulorrhaphy is indicated for patients who have imaging studies confirming the patient’s severe degenerative findings. The submitted x-ray revealed very mild degenerative joint disease. There is an indication the patient has a significant labral tear. However, given that the capsulorrhaphy surgery is not fully indicated the additional surgery is rendered non-certified. Given the non-certification of the surgery, the additional requests for medical clearance, pre-operative testing and the brachial plexus block are rendered non-certified as well. Peer to peer discussion was not achieved despite calls to office.”*

On August 14, 2014, noted the patient's right shoulder pain increased with activity and the request for right shoulder surgery was denied. A second letter of medical necessity was submitted and denied. The patient complained of constant 4/10 pain located in the right shoulder and the entire extremity. The patient was working with restrictions. He reported that external immobilization and oral medications helped his symptoms. Examination of the right shoulder revealed ROM was elevation 150 degrees (active) and 155 degrees (passive), external rotation 70 degrees (active), external rotation in abduction 80 degrees (active), internal rotation in abduction 70 degrees (active) and cross-body adduction CLE (active). Strength testing was 4/5 supraspinatus and infraspinatus in manual motor power. Palpation revealed positive diffuse tenderness in AC joint, periscapular area and trapezius. The patient was positive for guarding, Speed test and O'Brien test. opined that the explanation of the denial was not consistent with the standard of care and recommended proceeding with an IRO.

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

The request is for right shoulder arthroscopic shoulder capsulorrhaphy and distal clavicle. The claimant was injured on xx/xx/xx at work. He has MRI which documents tearing of the posterior labrum with partial tearing of the supraspinatus tendon. There is subluxation of the biceps tendon. These MRI findings do suggest that the claimant would likely benefit from surgical intervention; however, they do not support an absolute indication for shoulder surgery. Without documentation of nonsurgical treatment first followed by persistence of

symptomatology, surgery cannot be supported on review of these medical records.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
Official Disability Guidelines, Treatment in Workers Comp 18th edition,
Shoulder Chapter Updated 08/27/14.

Brachial plexus nerve blocks (regional anesthesia)

Recommended when used by experienced practitioners. Regional anesthesia of the upper extremity has several clinical applications and is reported to have several advantages over general anesthesia for orthopaedic surgery. These advantages, such as improved postoperative pain, decreased postoperative opioid administration, and reduced recovery time, have led to widespread acceptance of a variety of regional nerve blocks. Interscalene block is the most commonly used block for shoulder surgery. Other brachial plexus nerve blocks used for orthopaedic surgery of the upper extremity are supraclavicular, infraclavicular, and axillary. (Bruce, 2012)

Surgeons and patients are sometimes reluctant to support regional anesthesia for shoulder and other orthopedic surgeries due to the perceived potential for added morbidity, but both general anesthesia and regional anesthesia maintain their own particular benefits when used appropriately. (Boezaart, 2010) Interscalene block for shoulder surgery is at least as effective as general anesthesia alone or other regional anesthetic techniques for decreasing postoperative pain, the need for supplemental analgesics, and episodes of nausea and vomiting, and the associated complication rate is low. (Hughes, 2013) Interscalene nerve blocks (ISBs) have been shown to be an effective option for regional anesthesia in shoulder surgery. Among members of the American Shoulder and Elbow Surgeons, 60% would elect a single-shot ISB, 15% would elect a continuous catheter, and 26% would not elect the use of an ISB if undergoing shoulder surgery. Respondents from a university hospital were 1.44 times more likely to elect any ISB than respondents from a non-university hospital. Improved post-operative pain control was considered the greatest benefit, whereas persistent neuropathy was considered the greatest risk of ISB use. 76% would recommend use of ISB to their patients undergoing shoulder surgery. Studies that utilized a total of 6243 ISBs showed data resulting in a 0.35% major complication rate and an 11.32% minor complication rate in patients. ISB use is considered a safe and effective anesthetic option among shoulder surgeon specialists. (Moore, 2013) There has been resistance to the use of interscalene regional block for arthroscopic shoulder surgery because of concerns about potential complications and failed blocks with the subsequent need for general anesthesia, but this study concluded that

interscalene block can provide effective anesthesia for arthroscopic shoulder surgery with minimal complications. (Bishop, 2006)

**Official Disability Guidelines, Treatment in Workers Comp 18th edition, Shoulder Chapter Updated 08/27/14,.Surgery for SLAP lesions
Criteria for Surgery for SLAP lesions:**

- After 3 months of conservative treatment (NSAIDs, PT)**
- Type II lesions (fraying and degeneration of the superior labrum, normal biceps, no detachment)**
- Type IV lesions (more than 50% of the tendon is involved, vertical tear, bucket-handle tear of the superior labrum, which extends into biceps, intrasubstance tear)**
- Generally, type I and type III lesions do not need any treatment or are debrided**
- History and physical examinations and imaging indicate pathology**
- Definitive diagnosis of SLAP lesions is diagnostic arthroscopy**
- Age under 50 (otherwise consider Biceps tenodesis).**

**Official Disability Guidelines, Treatment in Workers Comp 18th edition, Shoulder Chapter Updated 08/27/14,.surgery for impingement syndrome
ODG Indications for Surgery -- Acromioplasty:**

Criteria for anterior acromioplasty with diagnosis of 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. 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 impingement.

(Washington, 2002)

**Official Disability Guidelines, Treatment in Workers Comp 18th edition, Shoulder Chapter Updated 08/27/14 Surgery for Shoulder dislocation
ODG Indications for Surgery -- Shoulder dislocation surgery:**

Criteria for capsulorrhaphy or Bankart procedure with diagnosis of recurrent glenohumeral dislocations:

- 1. Subjective Clinical Findings: History of multiple dislocations that inhibit activities of daily living. PLUS**
- 2. Objective Clinical Findings: At least one of the following: Positive apprehension findings. OR Injury to the humeral head. OR Documented dislocation under anesthesia. PLUS**
- 3. Imaging Clinical Findings: Conventional x-rays, AP and true lateral or axillary view.**

Criteria for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint:

- 1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS**
- 2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS**
- 3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS**
- 4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation.**

(Washington, 2002)

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

Official Disability Guidelines, Low Back Chapter, updated 08/22/14

Preoperative lab testing

Recommended as indicated below. Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient`s clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. (Feely, 2013) (Sousa, 2013)

Criteria for Preoperative lab testing:

- Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material.**
- Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure.**
- Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus.**
- In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management.**
- A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated.**
- Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants.**