

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

[Date notice sent to all parties]:

12/31/2014 and 01/07/2015

IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Arthroscopy
rotator cuff repair**

**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.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a male with an injury date of xx/xx/xx. On 10/03/14, he was seen in clinic with complaints of left shoulder pain as well as right hip bruising. X-rays of his left shoulder were negative for deformities, fractures, or separations. He had normal muscle strength and sensation was intact. On 10/31/14, an MRI of the left shoulder without contrast was limited secondary to motion artifact. There was a bursal sided partial tear of the conjoined tendon involving the posterior fibers of the supraspinatus and the anterior margin of the infraspinatus tendon at the junction on the greater tuberosity foot plate. There was also a partial interstitial tear of the superior fibers of the subscapularis. There was minimal degenerative arthrosis of the AC joint. On 11/13/14, this patient returned to clinic, and on exam, he had markedly limited active range of motion of his left shoulder but passively he was not

stiff. Range of motion was painful. He had a grossly positive Hawkins' sign with severe pain and weakness. Speed's, O'Brien's tests were all equivocal positive. AC joint was slightly tender at that time. Arthroscopic rotator cuff repair with SAD was recommended to him at that time.

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

On 11/26/14, a utilization review report was submitted for the requested decompression, rotator cuff repair, possible SLAP repair, proximal biceps tenotomy with and without tenodesis, with extensive debridement, limited synovectomy and other treatment as indicated. This request also included requests for a cryotherapy unit and an abduction airplane orthosis. It was noted at that time that the injury occurred in xx/xxxx and there was a partial thickness rotator cuff tear. It was noted there was less than 3 months of conservative care and there had been no physical therapy. There had been minimal attempts at conservative care and the request was not medically necessary based on evidence based guidelines. As the surgery was not medically necessary, postoperative DME was also not medically necessary. On 12/02/14, a utilization review report for the requested left shoulder diagnostic arthroscopy with subacromial decompression, rotator cuff repair, possible SLAP repair, proximal biceps tenotomy, with and without tenodesis, extensive debridement, limited synovectomy and other treatment as indicated was reviewed, finding that the request for surgery was not medically necessary as there were indications of limited conservative care for this patient and there was no indication of a full thickness rotator cuff tear. The surgery could be considered when there was a noted failure of at least 3 months of conservative treatment to include an active rehab program. As that was not documented, the requested surgery was not medically necessary. As the surgery was not medically necessary, the DME also was not medically necessary.

The MRI of the left shoulder without contrast dated 10/31/14 was submitted for review indicating that this study is limited by artifact. There was a focal bursal sided partial tear of the conjoined tendon. There was also a partial interstitial tear of the superior insertional fibers of the subscapularis tendon. There was minimal degenerative arthrosis of the AC joint and thus the findings on the MRI do not reveal indications for which surgery should precede conservative care. The records do not indicate that 3 months of consecutive conservative care has been attempted for this patient. No physical therapy notes were provided for the review. Therefore, it is the opinion of this reviewer that the request for arthroscopy with rotator cuff repair is not medically necessary and the prior denials are upheld.

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

ODG Indications for Surgeryä -- 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