

Vanguard MedReview, Inc.

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat right shoulder arthroscopy with rotator cuff repair

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

This reviewer is a Board Certified Orthopedic Surgeon with over 42 years of experience.

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]:

The claimant is a female who was injured on xx/xx/xx when pulling a cart out of the elevator at her job.

07/08/2014: Progress Note. **HPI:** 06/18/2014 Rt rotator cuff repair. Complaints: Continues with pain 7/10. Would like a refill on meds (Tramadol). She is able to move arm.

07/17/2014: Plan of Care, OTR. **HPI:** is a female, right hand dominant, who was referred to occupational therapy s/p rotator cuff repair on 6/18/2014. Patient was injured on xx/xx/xx when pulling a cart out of the elevator. She reported a popping sound with pain to her right shoulder. She was referred to her PCP and was referred to therapy on 01/16/2014. She completed 10 therapy visits with minimal progress made. She was referred back to her PCP who then referred her to . MRI revealed a torn rotator cuff to her right shoulder and required surgery on 6/18/14. She reports to her evaluation session in an arm sling. She reports she is able to perform basic activities of daily living independently with difficulty. Patient is eager to return to work once she is fully healed. Pain: Extremity Pain-Right upper extremity. At rest 3/10, with activity 6/10. Dull. Skilled analysis of safety deficits or

problems: Patient is s/p rotator cuff repair on 6/18/14. She presents to her therapy evaluation wearing her arm sling. Patient is presenting with decreased passive and active ROM to shoulder joint. There are multiple muscle spasms surrounding the shoulder girdle. She is also presenting with decreased muscle strength to rotator cuff muscles and surrounding shoulder muscles. Patient will benefit from occupational therapy to address deficits listed above. **Initial Evaluation Level:** Shoulder; Passive Right: Flexion: 110°, Extension: NT, Abduction: 100°, Adduction: WNL, Internal Rotation: NT. **Impairment Observations:** Muscle spasms with myofascial restrictions to surrounding shoulder musculature, shoulder pain and swelling secondary to surgery, decreased P/AROM to all planes, decreased muscle strength. Functional Limitation Report: Carrying, moving and handling objects functional limitation, current status, at therapy episode outset and at reporting intervals Current Status: CL- At least 60% but less than 80% impaired, limited or restricted. Carrying moving and handling objects functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting. Goal Status: CK-At least 40% but less than 60% impaired, limited or restricted. Carrying, moving and handling objects functional limitation, discharge status, at discharge from therapy or to end reporting Discharge Status: CH- 0% impaired, limited or restricted. **Intervention:** Frequency of OT: 3-5 times weekly Duration of OT: 6 weeks.

08/19/2014: Plan of Care. **HPI:** was seen for a 30 day re-evaluation since her initial therapy evaluation on 7/17/2014. She has completed 9 therapy visits as of 8/19/14 and has 7-8 remaining scheduled visits from her authorized therapy visits. She has made good progress thus far, reporting decreased pain and a gradual increase in ROM. Patient has been educated with a home exercise program. It is recommended that she continue with therapy until she has regained full shoulder AROM and good muscle strength as needed to return to work. **Current Shoulder Level:** Flexion: Active Right: 80° ROM Left: 180° Passive Right: 150° Extension: Active Right: 50° ROM Left: 60° Passive Right: WNL Abduction: Active Right: 80° ROM Left: 180° Passive Right: 150° Internal Rotation: Active Right: 70° ROM Left: 70° Passive Right: NT External Rotation: Active Right: 50° ROM Left: 90° Passive Right: 60° **Plan:** Continue OT

10/02/2014: Plan of Care. **HPI:** was seen of occupational therapy re-evaluation to assess her progress with therapy. Patient has been compliant with her scheduled therapy visits and with her home exercise program. She continues to complain of limited shoulder AROM to all planes and weakness. Progress has been slow but steady in my opinion because of the length of time from her date of injury to surgery date. Patient is eager to return to work but feels she is not able to perform most of her duties as a housekeeper. There are joint limitations as seen with limited PROM to all planes with a heard end feel. Therapy has focused on addressing joint stiffness and soft tissue restrictions to improve P/AROM. She will continue to benefit from therapy services to continue with progress made. Her home exercise program as reviewed and patient was given a set of shoulder pulley's to perform at home. **Current Evaluation:** Disabilities of the arm, shoulder and hand (DASH) score: 72. Current Level: Shoulder: Active ROM: Flexion: Active Right: 80° Active Left: 140° Extension: Active Right: 30° Active Left: NT

Abduction: Active Right: 70° Active Left: 125° Internal Rotation: Active Right: WNL Active Left: NT External Rotation: Active Right: 40° Active Left: NT Gross Grip Strength: Right: 17 Left: 37 Surgical incisions are completely healed. Muscle spasms with myofascial restrictions to surrounding shoulder musculature, shoulder pain and swelling secondary to surgery, decreased P/AROM to all planes, decreased muscle strength. **Plan:** Continue OT

03/17/2015: XR Arthrogram Shoulder Right. **Findings:** Reference is made to the previous MRI dated 3/6/14 and X-ray dated 11/14/13. There is adequate distention of the shoulder joint, subscapularis recess and infraxial recess, which rules out adhesive capsulitis. Contrast is also seen in the biceps tendon sheath. There is evidence of previous intervention with soft tissue anchors is seen overlying the humeral head. Visualized bones are otherwise unremarkable in cortical outline and trabecular density. No lytic or sclerotic lesion is seen. The acromioclavicular and shoulder joints are unremarkable. Contrast is seen in the region of subacromial-subdeltoid bursa, suspicious for rotator cuff tear. There is extension of contrast along the medial humeral neck. The superior labral outline is unremarkable, with no evidence of tear. **Impression:** 1. Evidence of previous intervention with soft tissue anchors seen overlying the humeral head. 2. Contrast seen in the region of subacromial-subdeltoid bursa, suspicious for rotator cuff tear. 3. Extension of contrast along the medial humeral neck.

03/17/2015: MRI Shoulder w/o contrast right. **Impression:** 1. Limited evaluation possible due to susceptibility artifacts seen in the super lateral part of humeral head and adjacent soft tissues, likely to be due to previous intervention. 2. Mild degenerative hypertrophic changes in the acromioclavicular joint with mild subchondral marrow edema in the clavicle, causing mild compromise of the subacromial space. 3. Partial thickness tear of infraspinatus tendon involving the synovial surface and measuring 19 mm anteroposteriorly and 30mm along the length of the tendon fibers. 4. Subscapularis tendon and insertion of supraspinatus tendon not adequately evaluated due to artifact. 5. Fraying of the superior glenohumeral ligament, compatible with partial tear. 6. Extension of contrast along the medial humeral neck with soft tissue strands seen in that region, possibility of tear at humeral attachment of inferior glenohumeral ligament. 7. Soft tissue edema in the subcutaneous fat plane and deltoid muscle on the anterior aspect of shoulder, likely to be procedure related.

04/21/2015: Office Visit. **HPI:** Patient is here with right shoulder pain, 8/10 pain, pt is taking celecoxib. MRI taken at LMC on 3/17/15. Problems: Obesity, Rt shoulder pain. Medicines: Tramadol 50 mg oral tablet. Take one tab oral every 4 hours for pain, 1 refill.

04/28/2015: UR. **Rationale for Denial:** The ODG supports the use of operative intervention for the management of rotator cuff pathology as outlined below. This particular case, the injured worker previously underwent a rotator cuff repair. A recent clinical evaluation has not been included. While it is noted that the arthrogram reveals possible evidence of a rotator cuff tear, it does not appear that any recent advanced imaging has been completed. Furthermore, given the lack of

a recent clinical evaluation request is considered not medically necessary and is recommended for non-certification.

06/01/2015: UR. **Rationale for Denial:** Applicable clinical practice guidelines normally support rotator cuff repair and associated procedures to treat significant full-thickness rotator cuff tears in the shoulder when cervical radiculopathy and/or adhesive capsulitis are excluded as the cause for symptoms and for small full-thickness rotator cuff tears after completing conservative treatment including a rehabilitative exercises to normalize shoulder ROM and strength and balance the supporting muscles about the shoulder, and guidelines reserve revision rotator cuff repair for individuals who have undergone only a single previous rotator cuff repair and who have undergone only a single previous rotator cuff repair and who have inability to elevate the shoulder above the horizontal and no disruption of the deltoid and good quality rotator cuff tissue. This individual underwent previous right shoulder arthroscopy and rotator cuff repair just under 1 year ago and she attended postoperative PT and was working on overcoming deficits of passive ROM suggestive of adhesive capsulitis as of 6 months ago but there is no report of her measured ROM progress since 11/2014, and no report of imaging that demonstrates the quality of the rotator cuff tissue although an arthrogram is said to show some leakage of dye which may be due to a rotator cuff tear or leakage through the previous repair site, so the medical necessity for proceeding with a repeat right shoulder arthroscopy and rotator cuff repair is not clearly established.

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

The previous adverse determinations are upheld. There is no recent clinical evaluation and range of motion measurements. There are only possible or suspicious findings on the MRI. ODG guidelines for surgery are not met without up to date clinical exam. Repeat right shoulder arthroscopy with rotator cuff repair is not certified.

Per ODG:

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 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 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).

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)