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Notice of Independent Review Decision

**[Date notice sent to all parties]:**

**8/21/2015**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Right shoulder manipulation under anesthesia, arthroscopy with capsular release, acromioplasty, distal clavicle excision, extensive debridement, loose body removal, biceps tenodesis and possible rotator cuff repair with shoulder orthosis

**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]:** The patient is a male with a reported injury on xxxx. The injury reportedly occurred when the patient stepped in a hole, lost his balance, and fell. His diagnoses were noted to include adhesive capsulitis, history of displaced 4 part proximal humerus fracture, and rotator cuff insertion intact without evidence of tearing. His medications were noted to include Flomax, simvastatin, and glipizide ER. His surgical history was noted to include an unspecified knee replacement. His diagnostic testing has included a CT of the right shoulder without contrast on xxxx which reported remote fracture of the right humerus as osseously bridged with residual foreshortening and angulation at the fracture line. An MRI of the right shoulder, dated xxxx, reported: (1) acute comminuted, intra-articular fracture at the humeral head and neck with marked inferior medial subluxation of the humeral head fragment; (2) the rotator cuff tendons

remain intact to fragments of the greater tuberosity of the humerus with no significant displacement; (3) effusion at the glenohumeral joint; (4) intramuscular edema within the deltoid, infraspinatus, and teres minor; and (5) periarticular soft tissue swelling. His other therapies have included activity modification, the use of a sling, medications, and at least 21 sessions of physical therapy. A physical therapy re-evaluation note dated xxxx indicates that active right shoulder range of motion measured 100 degrees of flexion and 95 degrees of abduction. Passive range of motion measured 123 degrees of flexion, 118 degrees of abduction, 70 degrees of internal rotation, and 65 degrees of external rotation. The patient was evaluated on xxxx for complaints of right shoulder pain. The patient reported that his pain had been gradually worsening and was described as a moderate dull aching. The patient's pain was aggravated by overhead activity and lifting. Associated features included painful range of motion, decreased range of motion, difficulty with overhead activities, difficulty dressing himself, difficulty with pushing, difficulty with pulling, and difficulty with lifting. The patient requested surgical intervention. Physical examination of the right shoulder revealed the patient to be neurovascularly intact with normal sensation and deep tendon reflexes. Manual motor strength testing measured 5/5 throughout with the exception of the supraspinatus, which measured 3/5 and the infraspinatus, which measured 4/5. Incidentally, the contralateral side measured 5/5 throughout. There was popping on movement of the right shoulder, Hawkins/Kennedy impingement test was positive, impingement test was positive, Neer's AC differentiation test was positive, and Neer's impingement test was positive. AC crossover adduction test was positive, biceps load test was positive, infraspinatus test was positive, Jobe's test was positive, O'Brien's test was positive, SLAP prehension test was positive, Speed's test was positive, supraspinatus test was positive, and Yergason's test was positive. The clinician indicated that the patient continued to have activity limiting shoulder pain with limited range of motion that had not improved with conservative treatment, including medications, physical therapy, and a cortisone injection. The clinician's treatment plan was for surgical intervention, including a right shoulder manipulation under anesthesia arthroscopy with capsular release, acromioplasty, distal clavicle excision, extensive debridement, loose body removal, biceps tenodesis, and possible rotator cuff repair. The risks and benefits of surgery were discussed.

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

The Official Disability Guidelines state that manipulation under anesthesia and surgery for adhesive capsulitis are currently under study. Manipulation under anesthesia may be considered when range of motion remains significantly restricted after xxxx months of conservative therapy and abduction is less than 90 degrees. As the provided documentation indicates that the patient's right shoulder abduction was greater than 90 degrees, both passively and actively, manipulation under anesthesia is not supported. The Official Disability Guidelines state that a high quality study is required to definitively evaluate the relative benefits regarding surgical intervention for adhesive capsulitis. As such, the request for arthroscopy with capsular release is not supported. The Official Disability Guidelines

recommend acromioplasty when certain criteria have been met. While the patient has completed xxxx of conservative care and has pain with active arc motion, the most recent documentation did not indicate that the patient had pain at night. The patient's right shoulder abduction measured greater than 90 degrees both passively and actively and there was no documentation of atrophy; however, motor strength testing did measure 3/5 at the supraspinatus and 4/5 at the infraspinatus. The most recent physical examination revealed no tenderness to palpation, pain, or palpable swelling. Impingement sign was positive; however, the provided documentation did not indicate temporary relief of pain with anesthetic injection. The most recent diagnostic testing was a CT scan on xxxx which did report acromioclavicular osteoarthritis but did not report evidence of impingement. As such, acromioplasty is not supported. The Official Disability Guidelines recommend partial clavicle resection when certain criteria have been met. The most recent physical examination did not indicate pain at the acromioclavicular joint or previous grade 1 or 2 acromioclavicular separation. There was no tenderness over the acromioclavicular joint with palpation or documentation of pain relief obtained with an injection of an anesthetic for a diagnostic or therapeutic trial. Additionally, while the most recent CT scan of the shoulder did report acromioclavicular osteoarthritis, there was no documentation indicating post-traumatic changes of the acromioclavicular joint, severe degenerative joint disease of the acromioclavicular joint, or complete or incomplete separation of the acromioclavicular joint. As such, distal clavicle excision is not supported. Extensive debridement is not supported based on the guidelines for impingement syndrome and adhesive capsulitis. There were no diagnostic imaging studies to support retained loose bodies requiring removal. The Official Disability Guidelines recommend biceps tenodesis when certain criteria have been met. The most recent MRI of the right shoulder, dated xxxx, indicated that the biceps tendon was intact and there was no evidence of labral tear. As such, biceps tenodesis is not supported. The Official Disability Guidelines recommend rotator cuff repair when certain criteria have been met. The most recent MRI provided for review, dated xxxx, indicated that the rotator cuff tendons were intact without significant displacement. As such, rotator cuff repair is not supported. based on the documentation submitted, and in consideration of the diagnoses, the care provided, and clinical condition, as well as the medical history of this patient, the requested right shoulder manipulation under anesthesia, arthroscopy with capsular release, "acromioplasty," distal clavicle excision, extensive debridement, loose body removal, biceps tenodesis, and possible rotator cuff repair with shoulder orthosis is not medically necessary based on the Official Disability Guidelines and current standards of care. Therefore, the previous adverse determination should be upheld.

## IRO REVIEWER REPORT TEMPLATE -WC

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

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

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2015, Shoulder (Acute & Chronic)/ Manipulation under anesthesia (MUA).

Under study as an option in adhesive capsulitis. In cases that are refractory to conservative therapy lasting at least 3-6 months where range-of-motion remains significantly restricted (abduction less than 90°), manipulation under anesthesia may be considered.

Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2015, Shoulder (Acute & Chronic)/ Surgery for adhesive capsulitis.

Under study. The clinical course of this condition is considered self-limiting, and conservative treatment (physical therapy and NSAIDs) is a good long-term treatment regimen for adhesive capsulitis, but there is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment.

A high quality study is required to definitively evaluate the relative benefits of these procedures.

Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2015, Shoulder (Acute & Chronic)/ Surgery for impingement syndrome.

Operative treatment, including isolated distal clavicle resection or subacromial decompression (with or without rotator cuff repair), may be considered in the treatment of patients whose condition does not improve after 6 months of conservative therapy or of patients younger than 60 years with debilitating symptoms that impair function.

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 MRI, ultrasound, or arthrogram shows positive evidence of impingement.

(Washington, 2002)

Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2015, Shoulder (Acute & Chronic)/ Partial claviclectomy (Mumford procedure).

ODG Indications for Surgery -- Partial claviclectomy:

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.

Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2015, Shoulder (Acute & Chronic)/ Biceps tenodesis.

Criteria for Surgery for Biceps tenodesis:

- 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
- Also patients undergoing concomitant rotator cuff repair
- History and physical examinations and imaging indicate pathology
- Definitive diagnosis of SLAP lesions is diagnostic arthroscopy
- Age over 40 (otherwise consider SLAP repair).

Official Disability Guidelines (ODG), Treatment Index, 11th Edition

(web), 2015, Shoulder (Acute & Chronic)/ Surgery for rotator cuff repair.

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).