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DATE: 5/27/16

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
29827 Left Shoulder Rotator Cuff Repair

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is certified by The American Board of Orthopedic Surgeons and has over 17 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 male with left shoulder pain after falling from a ladder on XX/XX/XX.

XX/XX/XX: Left shoulder x-ray: Impression: Postoperative changes s/p acromioplasty and resection of the distal end of the clavicle. Greater tuberosity findings are compatible with possible postoperative changes or residua of chronic shoulder impingement.

XX/XX/XX: Office visit. HPI: The patient returns today and he is still having pain. He feels that it is not getting better. He is about to come off worker's comp and will now be on disability. He has difficulty raising his arm. He has constant pain and night pain. He has limitations with regards to ROM. He still has weakness and occasional crepitus. Plan: 1. S/P revision RCR L shoulder. The patient has continued pain and weakness. I recommended a repeat MRI. He is to continue ROM and PT as tolerated. F/U MRI.

XX/XX/XX: MRI of left shoulder. Impression: 1. Prior rotator cuff repair with chronic-full thickness, near-complete tear of the supraspinatus tendon with approximately 2cm retraction and severe muscular atrophy. 2. Limited evaluation of the infraspinatous tendon due to the susceptibility metallic artifact with partial tear or postoperative changes. 3. Nonvisualization of the bicipital tendon at the rotator interval with distal reconstitution in the intertubercular tube which may be sequela of prior tenodesis.

XX/XX/XX: Follow-up. This visit does not mention shoulder at all, only his blood pressure problem.

XX/XX/XX: UR. Rationale: Peer to peer was attempted but not established. This request is for a left shoulder rotator cuff repair. The records indicate the patient had previous rotator cuff repair with subsequent re-tear. He has also

undergone acromioplasty. The records indicate that there is full thickness near complete tear of the supraspinatus tendon, but a complete examination to correlate with that MRI has not been provided for the review. Therefore, the request would not be supported and is non-certified.

XX/XX/XX: UR. Rationale: This is an appeal to a previously denied request. The previous review did not approve the request due to the lack of complete examination to correlate with the MRI. No additional medical records were submitted for review. In this case, the most recent examination was XX/XX/XX and did not contain physical examination findings for the left shoulder. The most recent physical exam was XX/XXXX and did not contain enough information to substantiate the request. There was no discussion regarding conservative treatments rendered in the interim after the 3rd surgery. The ODG supports surgical intervention for patients with a diagnosis of partial thickness rotator cuff tear or acromial impingement syndrome, subjective and objective findings that support a diagnosis of impingement must be documented, and accompanied by imaging corroborating evidence of impingement. Considering this, the request cannot be substantiated. The issue raised by the previous review remains unaddressed. Recommend non-certification.

XX/XX/XX: UR. Rationale: This is a request to reconsider a prior appeal for a left shoulder rotator cuff repair. The claimant has chronic rotator cuff pathology. The fact that he has previously undergone multiple left shoulder surgeries, including 2 prior rotator cuff repairs, as well as severe muscular atrophy and 2-cm retraction, suggest a poor prognosis for an additional rotator cuff repair. There should be more detailed documentation of physical examination findings, including complete ROM measurements, specific examination for the rotator cuff, or provocative testing. There should be more documentation of conservative treatment rendered since the most recent surgery, as well as discussion of alternative treatment approaches for this patient who has repeatedly failed rotator cuff repair. Spoke with XXXXX and discussed the case. The agreement was reached that an addendum note will be faxed from the requesting physician with his specific reasons that establish a 3rd rotator cuff repair of a severely atrophied supraspinatus with 2 cm retraction would be beneficial and successful. However, no additional records were provided via fax transmission. Non- certify.

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

Upon Independent Review, the reviewing physician finds that the previous adverse determination is upheld. The request for rotator cuff repair is denied. The patient is currently dealing with pain and weakness in the left shoulder following two prior shoulder surgeries. His recent MRI study demonstrates 2 cm of tendon retraction with severe atrophy of the rotator cuff muscles. It is unclear from the records reviewed whether the patient is a surgical candidate. There is no mention of active shoulder motion, strength testing, or provocative maneuvers. There is no documentation of conservative treatment with medication, physical therapy and injections. Rotator cuff repair in this patient carries a poor prognosis because of the degree of severe muscle atrophy. Rotator cuff repair would not be appropriate for this patient. Therefore, the left rotator cuff repair is not medically necessary for this patient.

PER ODG…….

Surgery for rotator cuff repair	Recommended as indicated below. Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, but the outcomes from open repair are as good or better. Surgery is not indicated for patients with mild symptoms or those who have no limitations of activities. (Ejnisman-Cochrane, 2004) (Grant, 2004) Lesions of the rotator cuff are best thought of as a continuum, from mild inflammation and degeneration to full avulsions. Studies of normal subjects document the

	universal presence of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment but without surgical risks. Studies evaluating results of conservative treatment of full-thickness rotator cuff tears have shown an 82-86% success rate for patients presenting within three months of injury. The efficacy of arthroscopic decompression for full-thickness tears depends on the size of the tear; one study reported satisfactory results in 90% of patients with small tears. A prior study by the same group reported satisfactory results in 86% of patients who underwent open repair for larger tears. Surgical outcomes are much better in younger patients with a rotator cuff tear, than in older patients, who may be suffering from degenerative changes in the rotator cuff. Referral for surgical consultation may be indicated for patients who have: Activity limitation for more than three months, plus existence of a surgical lesion; Failure of exercise programs to increase range of motion and strength of the musculature around the shoulder, plus existence of a surgical lesion; Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair; Red flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.). Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears are treated the same as impingement syndrome regardless of MRI findings. Outpatient rotator cuff repair is a well accepted and cost effective procedure. (Cordasco, 2000) Difference between surgery & exercise was not significant. (Brox, 1999) There is significant variation in surgical decision-making and a lack of clinical agreement among orthopaedic surgeons about rotator cuff surgery. (Dunn, 2005) For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopaedic referral. Patients with small tears of the rotator cuff may be referred to an orthopaedist after 6 to 12 weeks of conservative treatment. (Burbank2, 2008) Patients with workers' compensation claims have worse outcomes after rotator cuff repair. (Henn, 2008) *Revision rotator cuff repair:* The results of revision rotator cuff repair are inferior to those of primary repair. While pain relief may be achieved in most patients, selection criteria should include patients with an intact deltoid origin, good-quality rotator cuff tissue, preoperative elevation above the horizontal, and only one prior procedure. (Djurasovic, 2001) *Recent research:* Evidence on the pros and cons of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive, an AHRQ comparative effectiveness review concluded. While the data are sparse, patients improved substantially with all interventions; there were few clinically important differences between approaches, and complications were rare. Most patients try to resolve their pain and disability with a course of physical therapy before attempting surgery, but the study found very little good quality research to guide the choice of nonoperative treatment, the timing of treatment, and who would most benefit from various forms of treatment. Four out of five studies comparing surgical and nonsurgical management favored operative repair, but the evidence was too limited to make conclusions regarding comparative effectiveness. 113 studies comparing various operations found no differences in functional outcomes between open vs mini-open repair, mini-open vs arthroscopic repair, arthroscopic repairs with vs without acromioplasty, and single-row vs double-row fixation. Patients who had mini-open repair returned to work about a month earlier than patients who had open repair. On the other hand, functional improvement was better after open repair compared with arthroscopic debridement. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain. One study found no difference in range of motion or strength, while another suggested that adding continuous passive motion shortened the time until return to work and the time to 90 degrees abduction. For other postoperative rehabilitation strategies, one study showed that progressive loading reduced pain compared to traditional loading. In general, though, most studies found no

	difference in health-related quality of life, function, pain, range of motion, and strength with one approach versus another (e.g., with or without aquatics, individualized vs at home alone, videotape vs therapist-based, etc.). In the 72 studies that assessed prognostic factors, older age, increasing tear size, and greater preoperative symptoms were consistently associated with recurrent tears, whereas gender, workers' compensation status, and duration of symptoms usually did not predict poorer outcomes. (Seida, 2010) **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)**