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**Date notice sent to all parties:** 05/27/16

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Right shoulder arthroscopy, subacromial decompression, possible rotator tendon repair, and possible graft jacket

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

Board Certified in Orthopedic Surgery  
Diplomate of the American Board of Orthopedic Surgery  
Fellow of the American Academy of Orthopedic Surgeons  
Fellow of the American Association of Orthopedic Surgeons

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Right shoulder arthroscopy – Upheld  
Subacromial decompression – Upheld  
Possible rotator tendon repair – Upheld  
Possible graft jacket – Upheld

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

A right shoulder MRI dated XX/XX/XX was a limited study due to patient body habitus. There was a full thickness retracted tear of the supraspinatus tendon and a likely high grade interstitial partial thickness tearing of the infraspinatus tendon distribution. Some subscapularis tendinosis was noted, as well as AC joint presumed degenerative arthropathy. There was a small amount of subacromial/subdeltoid bursal fluid and a small to moderate glenohumeral effusion. XX examined the patient on XX/XX/XX. She was XX inches tall and weighed XXX pounds. She injured her right shoulder when she fell with a DOI of XX/XX/XX. She had another fall at work on XX/XX/XX and she had a full thickness rotator cuff tear for which she was going to delay surgery. However, the second fall made her shoulder much more painful. She was noted to have very heavy set arms. The MRI was reviewed and the impression was symptomatic rotator cuff interval. A subacromial injection was performed and surgery would be scheduled, which was approved on XX/XX/XX. On XX/XX/XX, a letter from XX indicated the compensable injury was accepted as a right shoulder sprain/strain and denied the full thickness tear, partial thickness tear, and AC joint arthropathy. A causation letter was requested at that time, which XX provided on XX/XX/XX. It was noted the patient had a non-work related fall in XX/XXXX, injuring her right shoulder. An MRI showed some inflammation and possible partial thickness tears of the rotator cuff however, no full thickness tear was specifically identified and she improved with conservative treatment. She returned to work full duty and on XX/XX/XX, she fell on the job and caught herself with the extended right upper extremity with the immediate onset of right shoulder pain and weakness. An MRI shortly after revealed a full thickness rotator cuff tear. XX felt the MRI showed a clear and marked exacerbation of the patient's condition in her right shoulder. He stated he fully supported that her second injury is the causative event for her current condition that would not improve without surgical care. The patient then underwent right shoulder arthroscopy, limited debridement, subacromial decompression and release of coracoacromial ligament, and mini open deltoid splitting rotator cuff interval repair on XX/XX/XX. The postoperative diagnoses were rotator cuff impingement with interval tear and biceps tendon tear. On XX/XX/XX, XX advised the patient to take the pillow off of her sling and to perform passive ROM only. She would remain off of work. The patient then returned to XX. She was six weeks status post surgery with some pain in the shoulder, but now numbness in the fingers, which might be an exacerbation of her preexisting CTS. She would remain off of work for one month and return. Continued therapy was recommended, which was approved on XX/XX/XX. On XX/XX/XX, the patient informed XX she had attended four therapy sessions. Flexion was to 130 degrees and she had some loss of external rotation with weakness. She was advised to continue ROM and to return in one month. It appeared the patient was evaluated in therapy on XX/XX/XX, but the copy was difficult to read. On XX/XX/XX, 12 sessions of therapy were approved. The patient had very good motion when she returned to XX, but she had no strength in the shoulder. Light duty and therapy were continued. The patient related to XX, she had very good motion, but related significant deconditioning and weakness with lack of stamina

in the shoulder. She also sometimes had an ache in the elbow area at night. Continued therapy was again recommended. The patient then attended therapy on XX/XX/XX, XX/XX/XX and XX/XX/XX. The patient's shoulder was doing excellent when she returned on XX/XX/XX. She had a burning sensation and pain that went from her shoulder all the way to the elbow. She had good range of motion on exam with no weakness or pain with supraspinatus stress. She had pain at rest and noted a burning and pins and needles sensation that XX noted might be related to a secondary problem other than the right shoulder that occurred during her fall. An EMG/NCV study was recommended and then performed on XX/XX/XX. There was no electrodiagnostic evidence of cervical radiculopathy, peripheral neuropathy, or myopathy. She had recurrent focal entrapment neuropathy at the right median nerve at the wrist, CTS. XX also evaluated the patient that day. She was six months status post surgery and still had weakness and pain in the right shoulder. He spoke with XX regarding the EMG/NCV study, which showed CTS on the right. Her main complaint was that she could not progress in the last three months and get all her strength back. She stated she was too weak to even turn a steering wheel. Exam showed fairly good flexion and the impression was a possible recurrent tear. A subacromial injection was performed. A right shoulder MRI arthrogram on XX/XX/XX revealed a retracted full thickness rotator cuff tear of the supraspinatus and infraspinatus tendons, as well as a partial tear of the subscapularis tendon. Long head biceps tendinosis was also noted. XX reviewed the study on XX/XX/XX and the risks and benefits of surgery were discussed. A right shoulder arthroscopy with subacromial decompression, possible rotator cuff repair, and possible graft jacket was recommended, which was denied on XX/XX/XX. XX reevaluated the patient and she had pain at rest and at night, as well as difficulty using her arm above her head. She had atrophy of the deltoid and flexion to 110 degrees with weakness after that. Abduction was 90 degrees and external rotation was limited by 15 degrees. Supraspinatus strength was 3/5. The impression was failed repair of the rotator cuff with retraction, weakness, and pain. The surgical procedure was again recommended, which was denied on XX/XX/XX.

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

The patient is an obese (XX feet XX inches, XXX pounds, body mass index equal to XX) female who was reported to have sustained a work-related injury on XX/XX/XX when she tripped over a XXXXX and fell. She has subsequently undergone a right shoulder arthroscopy with subacromial decompression, biceps tenotomy, and mini open rotator cuff repair on XX/XX/XX. Her postoperative visits have minimal physical examination findings and the majority of the therapy notes are illegible. XX, documented that her shoulder was doing excellent with full range of motion and no weakness. This is in contrast to repeat MRI arthrogram performed on XX/XX/XX, which revealed retracted full thickness tears of the supraspinatus and infraspinatus with 4.5 cm of retraction, possible partial thickness subscapularis tear, type 2 acromion, and long head biceps tendinosis. There are several discrepancies between the more recent MRI scan and the

reported surgical procedure of XX/XX/XX. XX recommended repeat surgery to the patient. XX non-certified the requested procedure. His denial was upheld on reconsideration/appeal on XX/XX/XX. XX noted the paucity of physical examination findings in his review. XX then reported deltoid atrophy, active flexion of 110 degrees, active abduction of 0 degrees to 90 degrees, and difference in external rotation of 15 degrees compared to the contralateral side, passive painful arc, and pain with cross-over maneuver. Both reviewers based their opinions on the evidence based Official Disability Guidelines (ODG).

The evidence based ODG criteria for the requested components of the procedure are as outlined below. The ODG indications for acromioplasty include the following criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery): 1) Conservative care, recommend three to six months. Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full range of motion, which requires both stretching and strengthening to balance the musculature; plus, 2) subjective clinical findings to include pain with active arc motion 90 degrees to 130 degrees and pain at night; plus, 3) objective clinical findings to include 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 to include conventional x-rays, AP and true lateral or axillary view, and MRI scan, ultrasound, or arthrogram showing positive evidence of impingement.

Surgery for rotator cuff repair is 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 good or better. Surgery is not indicated for patients with mild symptoms or those who have no limitations of activities (Cochran 2004). The ODG indications for surgery for rotator cuff repair include the following criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear and cervical pathology and frozen shoulder syndrome ruled out: 1) Subjective clinical findings of shoulder pain and inability to elevate the arm, tenderness over the greater tuberosity common in acute cases; plus; 2) objective clinical findings to include patient may have weakness with abduction testing, may also demonstrate atrophy of shoulder musculature, usually has full active range of motion; plus, 3) imaging clinical findings to include conventional x-rays, AP and true lateral or axillary views, and MRI scan, ultrasound, or arthrogram showing positive evidence of deficit in the rotator cuff. The criteria for rotator cuff repair or anterior acromioplasty with diagnosis of partial thickness rotator cuff tear or acromial impingement syndrome include the following: 1) Conservative care, recommend three to six months.

Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full range of motion, which requires both stretching and strengthening to balance the musculature; plus, 2) subjective clinical findings of pain with active arc motion 90 degrees to 130 degrees and pain at night, tenderness over the greater tuberosity common in acute cases; plus, 3) objective clinical findings to include 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; plus, 4) imaging clinical findings to include conventional x-rays, AP and true lateral or axillary view, and MRI scan, ultrasound, or arthrogram showing positive evidence of deficit in the rotator cuff.

In addition, the use of graft jacket is under study. Over the past few years, many biological patches have been developed to augment repairs of large or complex rotator cuff tears. These patches include both allograft and xenograft. Regardless of their origins, these products are primarily composed of purified type 1 collagen. There is a lack of studies demonstrating which ones are effective (Coons 2006). For short-term periods, restoring a massive rotator cuff thin defect with synthetic graft can give significant pain relief, but there is still some risk of new tears (Audenaert 2006); see also amniotic membrane allograft (AmnioFix) for shoulder surgery, bioengineered tissue grafts for shoulder surgery, extracellular matrix for shoulder surgery, and graft jacket tissue matrix again for shoulder surgery. A graft jacket matrix for shoulder surgery is currently investigational at this time secondary to the lack of quality studies.

The procedure as requested cannot be certified since it does not meet the ODG criteria. There are significant inconsistencies between the repeat MRI scan and the index surgical procedure that have not been addressed by the surgeon. It is unclear if, in fact, this tear is repairable in this setting. Therefore, the requested right shoulder arthroscopy, subacromial decompression, possible rotator cuff repair, and possible graft jacket are not medically necessary, reasonable, related, or supported by the evidence based ODG and the previous adverse determinations should be upheld at this time.

**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)**