

AccuReview

An Independent Review Organization
569 TM West Parkway
West, TX 76691
Phone (254) 640-1738
Fax (888) 492-8305

[Date notice sent to all parties]: March 14, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

29824 Arthroscopy, shoulder; distal claviclectomy; 29826 Decompression of Subacromial Space; 29827 Arthroscopic Rotator Cuff Repair; 29828 Arthroscopy Shoulder Surgical Biceps

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

This physician is Board Certified in Orthopaedic Surgery with over 16 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]:

XX/XX/XX: Encounter Notes. CC: shoulder and arm injury. H&P: XX/XX/XX, claimant reported onset of arm pain as pulling on a large X at work on XX/XX/XX. He indicated pain to lateral aspect of left upper arm which is worse trying to reach and to turn a steering wheel. On XX/XX/XX, claimant reported not doing well, indicated predominantly lateral left shoulder pain and reported that is hurt with reaching across his body and to try to raise his left arm. Reported very little improvement with HEP and is working with restrictions. Today, the claimant has completed two PT sessions thus far with little improvement and complained of continued left shoulder pain, currently on light duty. PE: Left shoulder flexion to about 170 degrees and abduction to about 135 degrees, both with associated left shoulder pain. Pain with restricted left shoulder abduction and external rotation (but not restricted internal rotation or adduction). Assessment: Left shoulder strain (possible rotator cuff injury). Plan: continue PT, MRI scheduled XX/XX/XX, may continue Naprosyn as needed, continue work restrictions and F/U on XX/XX/XX.

XX/XX/XX: MR Shoulder W/O Contrast, Left. Impression: 1. 0.5 x 0.7 cm high-grade partial thickness bursal sided rotator cuff tear of the distal supraspinatus tendon. 2. Tendinosis of the distal subscapularis tendon, perhaps with mild articular sided fraying. 3. Mild subacromial fat effacement and mild bursitis. 4. Small degenerative tear of the posterior labrum with 2 mm para labral cyst.

XX/XX/XX: Progress Notes. CC: left shoulder pain. Onset 2 months ago while lifting a heavy jack over 60 lbs. Treatments attempted: X-ray/MRI; PT: for active ROM, stretching, strengthening, and local heat and HEP; and NSAIDs. Pain 8/10 with constant sore, stabbing, and tender. Associated symptoms: popping, clicking, and morning stiffness. PE: Claimant has had therapy with no progress and a positive MRI which includes a Rotator cuff tear and tendinosis of

the distal Clavicle with fraying a Labral cyst of 2 mm. After having rehab and no improvement with his ROM and symptoms are present on a daily basis. He has impingement and a drop arm sign, there is also severe pain upon flexion and severe limits with his work duties and increased pain at night and during heavy use. Left Shoulder: Tenderness to palpation: acromion, AC joint, clavicle, bicipital groove, scapular spine, humeral head and supraspinatus tendon. ROM: abduction 90, adduction 30, flexion 120, extension 30, internal rotation 45, external rotation 45, painful arc 45. Muscle strength significantly decreased throughout. Special Tests: Positive Neer sign, Hawkins sign, cross arm adduction, Yergason sign, O'Brien sign and Speed sign. Assessment: Left shoulder Rotator cuff tear, AC DJD, Tendinosis of the Subscapularis Tendon. Plan: work status light, to OR for Rotator cuff tear, distal clavicle and Tenolysis of the Subscap.

XX/XX/XX: UR. Reason for denial: This is a male who sustained an injury on XX/XX/XX and was diagnosed with left shoulder rotator cuff tear, AC, DJD, and tendinosis of the subscapularis tendon. Prior treatments included rest, PT for two sessions as of XX/XX/XX, HEP, and medications. The claimant was taking ibuprofen. According to the H&P on XX/XX/XX, the claimant complained of left shoulder pain with sudden onset. There was tenderness to palpation over the acromion, AC joint, clavicle, bicipital groove, scapular spine, humeral head, and supraspinatus tendon. There was no tenderness to palpation over the coracoid process. The treatment plan was to undergo surgery for rotator cuff tear, distal clavicle, and tenolysis of the subscapularis; unable to determine medical necessity, denied.

XX/XX/XX: Progress Notes. CC: left shoulder pain. Treatments: PT for one month and HEP, NSAIDs. Pain continues at 8/10 with constant sore, stabbing, tender throughout. Popping, clicking and morning stiffness. PE: Left Shoulder: Tenderness to palpation: acromion, AC joint, clavicle, bicipital groove, scapular spine, coracoid process, humeral head and supraspinatus tendon. ROM: abduction decreased, adduction decreased, flexion decreased, extension decreased, internal rotation decreased, external rotation decreased, painful arc yes, decreased. Muscle strength significantly decreased throughout. Special Tests: Positive Neer sign, Hawkins sign, cross arm adduction, Yergason sign, O'Brien sign and Speed sign. Positive direct and indirect impingement with positive drop arm and severe pain with ROM. Significant weak rotator cuff, positive apprehension. Assessment: Left shoulder sprain, Partial thickness rotator cuff tear, traumatic, Tendinosis of the distal Subscapularis Tendon, Bursitis, Impingement syndrome. Plan: work status light, Mobic and ultracet, refer to PT for active ROM, stretching, strengthening, local heat, ultrasound and electrical stimulation, continue local heat, Unitedmix, Resubmit for authorization for an arthroscopic examination of the left shoulder for rotator cuff repair, distal clavicle resection, and Tenolysis of the Subscapularis tendon. The purpose of the arthroscopic repair is to help the claimant gain back his ROM to the shoulder to be able to perform ADLs without pain and discomfort.

XX/XX/XX: UR. Reason for denial: The request was previously noncertified on XX/XX/XX, due to minimal amount of conservative care, of less than two months. Additional documentation included evaluation from XX/XX/XX. The request remains noncertified. The guidelines would require six months of conservative care. There is no documentation of conservative care with a cortisone injection into the shoulder, as required by the guidelines. There is no evidence on imaging of impingement or the rotator cuff or a defect in the biceps tendon. The reconsideration request for left shoulder arthroscopy with rotator cuff repair, distal clavicle resection, and biceps tenodesis is not medically necessary.

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

The request for left shoulder arthroscopy, with distal clavicle excision, subacromial decompression, arthroscopic rotator cuff repair and subscapularis tenolysis is denied. This claimant is currently dealing with shoulder pain following a work accident. He has diffuse tenderness in the shoulder, which includes tenderness at the acromioclavicular (AC) joint and the bicipital groove. He has a positive Hawkins sign and positive Neer sign. His MRI demonstrates a high-grade partial tear of the supraspinatus tendon, subscapularis tendonitis with articular sided fraying, AC joint arthritis, and a posterior labral tear. Prior to surgical consideration, the claimant should complete a glenohumeral cortisone injection to address the supraspinatus and subscapularis pathology. He should also complete a cortisone injection to the AC joint to determine whether his arthritis is in fact a source of pain that should be addressed surgically. It is unclear from the record whether the claimant has completed three months of continuous physical therapy or six months of intermittent physical therapy, as

recommended by the Official Disability Guidelines (ODG). The proposed surgery is not medically necessary at this point in time. Therefore, after reviewing the medical records and documentation provided, the request for 29824 Arthroscopy, shoulder; distal claviclectomy; 29826 Decompression of Subacromial Space; 29827 Arthroscopic Rotator Cuff Repair; 29828 Arthroscopy Shoulder Surgical Biceps is denied.

Per ODG:

<p>Diagnostic arthroscopy</p>	<p>Recommended as indicated below. Criteria for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear. (Washington, 2002) (de Jager, 2004) (Kaplan, 2004)</p> <p>For average hospital LOS if criteria are met, see Hospital length of stay (LOS).</p>
<p>Surgery for rotator cuff repair</p>	<p>ODG Indications for Surgery™ -- Rotator cuff repair:</p> <p>Criteria for rotator cuff repair with diagnosis of <u>full thickness</u> rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:</p> <ol style="list-style-type: none"> 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. <p>Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of <u>partial thickness</u> rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)</p> <ol style="list-style-type: none"> 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. <p>(Washington, 2002)</p> <p>For average hospital LOS if criteria are met, see Hospital length of stay (LOS).</p>
<p>Surgery for ruptured biceps tendon (at the shoulder)</p>	<p>ODG Indications for Surgery™ -- Ruptured biceps tendon surgery:</p> <p>Criteria for tenodesis of long head of biceps (Consideration of tenodesis should include the following: Patient should be a young adult; not recommended as an independent stand alone procedure. There must be evidence of an incomplete tear.) with diagnosis of <u>incomplete tear or fraying of the proximal biceps tendon</u> (The diagnosis of fraying is usually identified at the time of acromioplasty or rotator cuff repair so may require retrospective review.):</p>

	<p>1. Subjective Clinical Findings: Complaint of more than "normal" amount of pain that does not resolve with attempt to use arm. Pain and function fails to follow normal course of recovery. PLUS</p> <p>2. Objective Clinical Findings: Partial thickness tears do not have classical appearance of ruptured muscle. PLUS</p> <p>3. Imaging Clinical Findings: Same as that required to rule out full thickness rotator cuff tear: Conventional x-rays, AP and true lateral or axillary view. AND MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.</p> <p>Criteria for tenodesis of long head of biceps with diagnosis of <u>complete tear</u> of the proximal biceps tendon: Surgery almost never considered in full thickness ruptures. Also required:</p> <p>1. Subjective Clinical Findings: Pain, weakness, and deformity. PLUS</p> <p>2. Objective Clinical Findings: Classical appearance of ruptured muscle.</p> <p>Criteria for reinsertion of ruptured biceps tendon with diagnosis of distal rupture of the biceps tendon: All should be repaired within 2 to 3 weeks of injury or diagnosis. A diagnosis is made when the physician cannot palpate the insertion of the tendon at the patient's antecubital fossa. Surgery is not indicated if 3 or more months have elapsed.</p>
--	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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)