September 2, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Torn cartilage, ligament surgery on the left shoulder

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)  Medical documentation does not support the medical necessity of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on XXXX at work. He was tightening a XX. He experienced six pops in the shoulder and burning sensation.

On XXXX, per a note from XX the procedure recommended was shoulder arthroscopy exam, repair of labrum versus debridement, debridement of biceps stump, subacromial decompression and shoulder brace.

On XXXX, an x-ray of the left shoulder was performed. It showed stippled calcifications centrally at the metaphysis of the humerus consistent with the enchondroma seen on MRI. There were minimal sclerotic changes of greater tuberosity, well maintained clear space at the glenohumeral joint and no fracture. Lateral view showed the same centralized stippled calcification with concentric reduction and well
maintained clear space. Outlet view showed type II acromion. Uptilt view showed normal AC joint.

On XXXX, an MRI of the left shoulder was performed. It showed tendinosis of the rotator cuff tendon complex. There were mild degenerative changes involving the acromioclavicular joint (AC) articulation of the left shoulder. It showed evidence of a complex tear/rupture of the long head of the biceps tendon. There was a bone lesion involving the proximal left humerus.

On XXXX, XX evaluated the patient for left shoulder pain. He stated the shoulder was normal until the job injury. After the injury he felt six pops in the shoulder and had a burning sensation. His wife noticed that his biceps did not look the same as the other side. Since then he had pain on top of the shoulder, worse with overhead activities and reaching behind. He had been trying to avoid heavy work but had been working. Examination showed obvious Popeye deformity from ruptured long head of the biceps tendon. Range of motion (ROM) was painful. He had a markedly positive impingement sign. The diagnoses were shoulder pain and ruptured long head of the biceps tendon. The recommendation was proximal biceps tendon tear surgery.

On XXXX, a peer review was performed and the request for left shoulder arthroscopy exam, repair of labrum versus debridement of biceps stump subacromial decompression, shoulder brace and carotid Doppler was non-certified with the following rationale: Per the review of the submitted documentation, the patient has a biceps rupture that is more than 10 weeks old. There was a high risk that this will not be repairable at this point. There is no cuff tear indicated. There is a risk for stiffness with a superior labral tear from the anterior to posterior (SLAP) repair. There was an insufficient attempt at the conservative care. Therefore, the request for left shoulder arthroscopy exam, repair of labrum versus debridement of biceps stump subacromial decompression is neither medically necessary nor appropriate. 2). Due to the request for left shoulder arthroscopy exam, repair of labrum versus debridement of biceps stump subacromial decompression being recommended for denial, the requested shoulder brace is neither medically necessary nor appropriate. The peer based literature states that incorrect physical interpretation of date is the most common cause of error in the carotid duplex ultrasound screening performed in non-accredited vascular laboratories. Per the review the submitted documentation, there is no clinical rationale provided to support this testing. Per the peer discussion, the details of the case were discussed and it was noted that the patient is a smoker and this was the reason for a carotid Doppler. As the patient is a smoker this increases the risk for post-operative complication including a failure of healing and infection. Therefore, the request for carotid Doppler is neither medically necessary nor appropriate.

On XXXX, per a utilization review note the request for left shoulder arthroscopy exam, repair of labrum versus debridement of biceps stump subacromial decompression and durable medical equipment was denied.

On XXXX, XX evaluated the patient for a follow up visit. The patient stated the surgery was denied and he was going to appeal. He was more concerned about the shoulder pain, probably from impingement.

On XXXX, XX performed a peer review and upheld the request for left shoulder arthroscopy exam, repair of labrum versus debridement of biceps stump subacromial decompression and durable medical equipment with the following rationale: Based on the review of the submitted medical records, there was no indication that the patient had undergone any conservative treatment including physical therapy or injections. The ODG indicate arthroscopic debridement when the conservative therapies including NSAIDs, intra-articular steroid injections and physical therapy has been tried and failed for at least six months. The patient
continues to have subjective complaints and objective findings, but there is no documentation of any physical therapy. Therefore the request is not medically necessary or appropriate.

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

Based on Official Disability Guidelines, reconsideration for surgery would not be indicated. The request would still not be supported. The records still fail to demonstrate any evidence of specific conservative care including formal physical therapy or injection that has taken place. The claimant has a rupture to the biceps tendon which would not support an isolated surgical process. While the claimant presents with subjective complaints consistent with impingement, guidelines criteria would support a six month course of conservative management focused on rehabilitative efforts, including injections, before considering operative management. The request would not be supported as necessary.

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

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

  Official Disability Guidelines Treatment in Workers Comp, 21th Edition, 2016 Updates:

  Surgery for impingement syndrome
  Recommend acromioplasty for acromial impingement syndrome as indicated below, after at least 3-6 months of conservative care. Not recommended in conjunction with full-thickness rotator cuff repair. (Abrams, 2014)
  Surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. Since this diagnosis is on a continuum with other rotator cuff conditions, including rotator cuff syndrome and rotator cuff tendonitis, see also Surgery for rotator cuff repair. (Prochazka, 2001) (Ejnisman-Cochrane, 2004) (Grant, 2004)

  Arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff. (Gartsman, 2004) This systematic review comparing arthroscopic versus open acromioplasty, using data from four Level I and one Level II randomized controlled trials, could not find appreciable differences between arthroscopic and open surgery, in all measures, including pain, UCLA shoulder scores, range of motion, strength, the time required to perform surgery, and return to work. (Barfield, 2007)
  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. The results of conservative treatment vary, ongoing or worsening symptoms being reported by 30-40% patients at follow-up. Patients with more severe symptoms, longer duration of symptoms, and a hook-shaped acromion tend to have worse results than do other patients. (Hambly, 2007)
  A prospective randomised study compared the results of arthroscopic subacromial bursectomy alone with debridement of the subacromial bursa followed by acromioplasty in patients suffering from primary subacromial impingement without a rupture of the rotator cuff who had failed previous conservative treatment. At a mean follow-up of 2.5 years both bursectomy and acromioplasty gave good clinical results, and no statistically significant differences were found between the two treatments. The authors concluded that primary subacromial impingement
syndrome is largely an intrinsic degenerative condition rather than an extrinsic mechanical disorder. (Henkus, 2009) A recent RCT concluded that arthroscopic acromioplasty provides no clinically important effects over a structured and supervised exercise program alone in terms of subjective outcome or cost-effectiveness when measured at 24 months, and that structured exercise treatment should be the basis for treatment of shoulder impingement syndrome, with operative treatment offered judiciously. (Ketola, 2009) In this RCT, full-thickness rotator cuff repair outcomes were the same, with or without acromioplasty. Acromioplasty is commonly performed during arthroscopic rotator cuff repair, but it does not improve outcomes by 2-year follow-up. (Abrams, 2014) Non-contrast MRI is sufficient for rotator cuff tears, and contrast enhancement is recommended for SLAP tears. (Spencer, 2013) (Farshad-Amacker, 2013) (Arnold, 2012) (Major, 2011)

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 Treatment in Workers Comp, 21th Edition, 2016 Updates:
Shoulder chapter
Surgery for biceps tenodesis
Recommended as an option for type II or type IV SLAP lesions in patients over 40 years of age. See SLAP lesion diagnosis. Biceps tenodesis (suture of the end of the tendon to the bone) is a surgical procedure usually performed for the treatment of refractory biceps tendonitis of the shoulder. A biceps tenodesis may be performed as an isolated procedure, or part of a larger shoulder surgery such as a rotator cuff repair. Patients with biceps tendon problems may have a detachment of the biceps tendon from the socket of the shoulder (a SLAP tear), or they may have inflammation and irritation of the biceps tendon itself. A biceps tenodesis is usually performed in patients over the age of 40, whereas other procedures such as a SLAP repair may be attempted in younger patients. Individuals older than 35 years with an isolated type II SLAP lesion had a shorter postoperative recovery, a more predictable functional outcome, and a higher rate of satisfaction and return to activity with biceps tenodesis compared with a biceps repair. Based on these observations, biceps tenodesis is preferable to biceps repair for isolated type II SLAP lesions in non-overhead athletes older than 35 years. (Denard, 2014)

Surgical repair remains the gold standard for most type II and type IV SLAP lesions that fail nonoperative management. However, more recently reported data has demonstrated unacceptably high failure rates with primary repair of type II SLAP lesions. Biceps tenodesis may offer an acceptable, if not better, alternative to primary repair of SLAP lesions. This study adds to the evolving literature supporting biceps tenodesis as a viable treatment for type II and IV SLAP lesions. (Gottschalk, 2014) Successful arthroscopic repair of symptomatic superior labral tears in young athletes has been well documented.
Superior labral repair in patients older than 40 years is controversial, with concerns for residual postoperative pain, stiffness, and higher rates of revision surgery. While studies show that good outcomes can be obtained with SLAP repair in an older cohort of patients, age over 40 and workers’ compensation status are independent risk factors for increased surgical complications. The cumulative evidence supports labral debridement or biceps tenotomy over labral repair when an associated rotator cuff injury is present. (Erickson, 2014) Biceps tenodesis is a viable treatment option for SLAP repair. (Huri, 2014)

Practice trends indicate that the proportion of SLAP repairs has decreased over time, with an increase in biceps tenodesis and tenotomy. Increased patient age correlates with the likelihood of treatment with biceps tenodesis or tenotomy versus SLAP repair. For patients with isolated SLAP lesions, the proportion of SLAP repairs decreased from 69.3% to 44.8%, while biceps tenodesis increased from 1.9% to 18.8%, and biceps tenotomy increased from 0.4% to 1.7%. For patients undergoing concomitant rotator cuff repair, SLAP repair decreased from 60.2% to 15.3%, while biceps tenodesis or tenotomy increased from 6.0% to 28.0%. There was a significant difference in the mean age of patients undergoing SLAP repair (37.1 years) versus biceps tenodesis (47.2 years) versus biceps tenotomy (55.7 years). (Patterson, 2014) See also Surgery for SLAP lesions.

Criteria for Surgery for Biceps tenodesis:
- History and physical examinations and imaging indicate significant biceps tendon pathology
- After 3 months of failed conservative treatment (NSAIDs, injection and PT)
- Advanced biceps tendinopathy
- Type II SLAP lesions (fraying and some detachment)
- Type IV SLAP 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 SLAP lesions do not need any treatment
- Also patients undergoing concomitant rotator cuff repair
- Age 40 and older
- Below age 40 if undergoing concomitant rotator cuff repair