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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right Shoulder Arthroscopy with DME: Shoulder Cradle

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

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a XXXX with a history of an occupational claim from XXXX. The mechanism of injury was described as XXXX. XXXX was diagnosed with right shoulder pain and right shoulder/upper arm strain. An MRI of the right shoulder performed on XXXX revealed tendinosis of the supraspinatus tendon thinning, mild tendinosis of the infraspinatus and subscapularis, mild acromioclavicular joint arthritis without subacromial fluid or displacement of the myotendinous junction, mild fraying of the superior labrum, and intact glenohumeral ligaments. According to the submitted documentation, the patient had previously been recommended to undergo surgery for the shoulder. The request was non-certified on XXXX due to a lack of significant functional limitations to support surgical repair, and minimal up-to-date medical records. The request was then denied again on XXXX, as there was no evidence of a SLAP lesion type II or IV. Additionally, the request was denied again as there were no significant functional impairments noted to warrant the requested surgical procedure. Surgery was denied, the associated request for durable medical equipment, a shoulder cradle, was also non-certified. Following the denial, the patient was seen on XXXX with unchanged symptomology. The patient reported ongoing pain in the right shoulder and reported pain with motion and weakness. The patient reported pain with overhead activities, pain with reaching, and pain with other activities. An injection on XXXX provided temporary relief, and therapy had been undergone for the shoulder, although the patient remains symptomatic with popping. The MR arthrogram of the shoulder without contrast performed on XXXX revealed a SLAP tear at XX, mild supraspinatus,

infraspinatus and subscapularis tendinosis, small intra-articular long head of the biceps tendinosis, and a small full thickness anterior inferior glenoid chondral fissure with minimal delamination and underlying subchondral cystic marrow changes. The patient continued with pain and burning sensation with no significant changes and was on light work restrictions. The provider noted that the patient's initial MRI did not show a tear because it was not an arthrogram, although the second study was more specific for labral tears. The treatment plan included recommendation to remain on work restrictions and plans for follow-up. Physical examination revealed decreased range of motion in the shoulder secondary to pain, with tenderness to palpation over the greater tuberosity. There was also weakness secondary to pain. The request was submitted for arthroscopic SLAP repair as well as a shoulder cradle.

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

Regarding the requested arthroscopic SLAP repair with a shoulder cradle, the available documentation indicated that the patient had ongoing pain in the shoulder despite physical therapy and an injection. The request was previously denied due to insufficient documentation regarding significant functional deficits, no description of a type II or IV SLAP lesion to support surgical intervention, and a lack of updated clinical documentation. Although additional information was provided for review, including recent office visit notes dated XXXX indicating that the patient reported ongoing pain with activities of daily living, there was still no description of a type II or IV SLAP lesion on imaging to support the request. The request only revealed a SLAP tear at XX. Furthermore, guidelines indicate that SLAP repair may be indicated for patients who are younger than 35, although this patient was noted to be XXXX years of age. There was insufficient documentation to support overturning the previous denial. As such, the requested surgery is not supported. As the requested surgery is not supported, the requested DME: Shoulder cradle is also not supported.

Therefore, right shoulder arthroscopy with DME: Shoulder cranial remains not medically necessary, and the prior determination is upheld.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Shoulder, Surgery for SLAP lesions.