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An Independent Review Organization

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Description of the service or services in dispute:

Left shoulder arthroscopic evaluation, acromioplasty, acromioclavicular resection and possible biceps tenodesis.

29805 Arthroscopy of shoulder, diagnostic

29824 Arthroscopy of shoulder, surgical with Mumford procedure

29826 Arthroscopy of shoulder, surgical with decompression of subacromial space

29828 Arthroscopy biceps tenodesis

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgeon

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

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

Patient Clinical History (Summary)

The patient is a XXXX who was diagnosed with right carpal tunnel syndrome, degeneration of the right distal lunate, impingement syndrome of the left shoulder with tendinopathy, left carpal tunnel syndrome and left triangular fibrocartilage complex (TFCC) tear.

On XXXX, the patient sustained an injury when XXXX went to XXXX. XXXX dorsiflexed XXXX wrist and felt numbness and pain in the right wrist with a pulling sensation, but did not recall a popping sensation. The left side was injured in a similar manner. XXXX felt a pulling in the left shoulder. XXXX was seen at XXXX where therapy was ordered and Flexeril was prescribed. According to the patient, therapy made it worse. Since the incident, the patient had not been able to work.

On XXXX, XXXX was seen by XXXX (Orthopedic Surgery) for right and left-hand numbness and pain. XXXX presented for consultation of the left upper extremity. The medical history was significant for the fibromyalgia. Examination of the bilateral hands revealed a positive Tinel's over the transverse carpal ligament, positive compression test and a positive Watson's maneuver. Tenderness was noted over the scapholunate (SL) interval. Examination of the left hand demonstrated a positive Phalen's test while examination of the right hand revealed positive axial load with clicking. There was tenderness noted over the extensor carpi ulnaris (ECU) and the first dorsal extensor compartment. Examination of the left shoulder revealed tenderness over the anterior acromion, over the acromioclavicular (AC) joint and over the bicipital groove. Neer's test and Hawkins test were noted as positive. XXXX was unable to perform lifts due to the strain. The range of motion of the shoulder was 90 degrees of flexion, 30 degrees of extension, 90 degrees of abduction, 70 degrees of internal rotation and 80 degrees of external rotation.

The patient presented to XXXX (Orthopedic Surgery) on XXXX for a follow-up evaluation of XXXX left upper extremity. XXXX stated that XXXX continued to have pain in the left shoulder. XXXX noted that the right wrist did not bother XXXX as much. Examination of the left shoulder revealed tenderness to palpation over the anterior acromion as well as mild tenderness to palpation over the biceps and acromioclavicular joint. Neer test, Hawkins test, Speed's test and Jobe's test were positive. Thumb rotation to the back was at the level of L1. The range of motion of the shoulder was 110 degrees of flexion, 35 degrees of extension, 90 degrees of abduction, 40 degrees of internal rotation and 85 degrees of external rotation.

The treatment to date included medications (Ibuprofen, Tylenol, Oxycodone and Lyrica), physical therapy, cortisone injections into the left shoulder and transcutaneous electrical nerve stimulation (TENS) unit. XXXX received cortisone injections into the subacromial space of the left shoulder on XXXX, XXXX (helped for about three weeks), XXXX (helped for about three weeks), XXXX (helped for one week), XXXX and XXXX. Progress notes from XXXX provider indicates that therapy exacerbated the symptoms. The documentation also indicates that physical therapy was attended for XXXX through XXXX additional therapy was denied due to persistent pain and pending surgical intervention.

An MRI of the left shoulder performed on XXXX revealed tendinopathy of the supraspinatus and infraspinatus tendons without a frank tear, a small amount of fluid within the subacromial-subdeltoid bursa, type II acromion and degenerative hypertrophic changes of the acromioclavicular joint. There was no evidence of rotator cuff tear.

An MRI of the right wrist dated XXXX revealed degenerative changes of the distal lunate. Same dated, an MRI of the left wrist showed questionable small central triangular fibrocartilage discus (TFC) tear versus intrasubstance degeneration.

Per an initial determination letter by XXXX (Orthopedic Surgery) dated XXXX, the treatment request for left shoulder arthroscopic evaluation, acromioplasty, acromioclavicular resection and possible biceps tenodesis, as an outpatient, had been noncertified. The reason for denial was, "per the Official Disability Guidelines, shoulder arthroplasty is recommended after 6 months of conservative treatment. Indications for surgery include positive imaging (shoulder joint degeneration, severe joint space stenosis) and conservative therapies tried and failed for at least 6 months. The guidelines recommend acromioclavicular resection as an alternative to arthroplasty, with positive imaging of shoulder joint degeneration and 6 months failed conservative therapies. The patient has failed steroid injections. However, the MRI findings do not suggest shoulder joint degeneration, severe joint space stenosis or shoulder joint degeneration. Additionally, it is unclear how long the patient has tried physical therapy. As such, the request for left shoulder arthroscopy, acromioplasty, acromioclavicular resection and possible biceps tenodesis is non-certified."

Per a reconsideration determination letter by XXXX (Orthopedic Surgery) dated XXXX, the request for the left shoulder arthroscopic evaluation, acromioplasty, acromioclavicular resection and possible biceps tenodesis, as an outpatient, was considered as not medically necessary and therefore, had been denied. The reason for denial was, "according to the Official Disability Guidelines, acromioplasty is indicated when there is documentation noting failure of non-operative care for at least one year to include physical therapy, medications, and injection; functional limitations, pain with active arc motion between 90-130 degrees and pain at night; tenderness over the anterior acromial area, positive Impingement sign and temporary relief from an injection; and imaging noting the deficits. The guidelines indicate that surgery for acromioclavicular joint is indicated when there is documentation noting failure of non-operative care; functional limitation; tenderness over the acromioclavicular joint, acromioclavicular joint crepitus

and cross-arm test pain; and imaging noting moderate to severe acromioclavicular narrowing. Biceps tenodesis is indicated after failure of non-operative care with evidence of type II and IV tear. The clinical documentation submitted for review indicated this patient had pain to the shoulder despite injection. Tenderness was noted and XXXX had positive provocative test findings on physical examination. Imaging showed type II acromion. However, there was no documentation noting the exhaustion and failure of non-operative care to include physical therapy. There was also no information noting functional limitations, pain at night, pain with active arc motion, moderate to severe acromioclavicular narrowing, nor type II or IV SLAP tear on imaging. Consequently, the request is not supported.”

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The clinical documentation provided indicates extensive conservative treatment was provided, including oral medications, injections, and physical therapy. Physical therapy was attended from XXXX through XXXX. The exact number of visits completed is not clearly documented, but pain persisted despite therapy. The information from the treating provider indicates that the additional requested therapy was denied. Given the documented painful arc of motion, clear evidence of impingement on examination, and AC joint pain, the ODG criteria for diagnostic arthroscopy, distal clavicle resection, and subacromial decompression have been met. While the clinical progress notes do indicate a positive speed’s test, the MRI shows no evidence of abnormality within the biceps tendon and no evidence of labral tearing.

As such, the biceps tenodesis would not be supported by the clinical documentation submitted. This should not be misconstrued to indicate the biceps tenodesis should not be performed, but rather findings available prior to the operative intervention do not demonstrate sufficient pathology to warrant preauthorization of this procedure. If pathology is encountered during the operative intervention, then tenodesis may be required. Partial overturn of the previous denials is recommended with authorization of the diagnostic arthroscopy, subacromial decompression, and distal clavicle resection.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- AHRQ-Agency for Healthcare Research and Quality Guidelines DWC-Division of Workers
- Compensation Policies and Guidelines European Guidelines for Management of Chronic Low Back
- Pain Interqual Criteria
European Guidelines for Management of Chronic Low Back Pain
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment Guidelines
- Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)

ODG, 2018: Shoulder Chapter

Partial claviclectomy (Mumford procedure)

See Surgery for shoulder dislocation for more information and references.

ODG Indications for Surgery™ -- Partial claviclectomy:

Criteria for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint:

- 1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS*
- 2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS*
- 3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS*
- 4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation.*

Surgery for biceps tenodesis (or tenotomy)

Recommended for advanced biceps tendinopathy or rupture under age 55, as well as for a type II or type IV SLAP lesions in patients over 35 years of age.

See also SLAP lesion diagnosis; Surgery for SLAP lesions; Surgery for ruptured proximal biceps tendon (shoulder); and Surgery for rotator cuff repair for related indications and discussion.

Criteria for Surgery for Biceps tenodesis (or tenotomy):

- History, physical examination, and imaging indicate significant shoulder biceps tendon pathology or rupture*
- After 3 months of failed conservative treatment (NSAIDs, injection, and PT) unless combined with acute rotator cuff repair*
- An alternative to direct repair for type II SLAP lesions (fraying, some detachment) and type IV (> 50% of biceps tendon involved, vertical or bucket-handle tear of the superior labrum, extending into biceps)*
- Generally, type I and type III SLAP lesions do not need any treatment*
- Age > 35 with Type II and IV SLAP tears (younger optional if overhead throwing athlete)*
- Age < 55 for non-SLAP biceps pathology, especially with concomitant rotator cuff repair; tenotomy is more suitable for older patients (past age 55)*

Surgery for impingement syndrome

Not recommended as an isolated procedure since best-evidence regarding long-term clinical outcomes for surgery has consistently been no better than conservative treatment for subacromial impingement syndrome (SIS), rotator cuff tendinopathies, or in association with rotator cuff tears. While subacromial decompression (SAD) has been historically encouraged, 20-30% long-term failure rates have been recently reported, being especially poor for worker's compensation claimants. When pre-authorization is considered beyond these guidelines based on specific individual patient considerations, especially with other treatable shoulder pathology, then simple bursectomy/debridement is currently favored over acromioplasty. See contingent indications below.

See also Surgery for rotator cuff repair

ODG Indications for Surgery™ -- Bursectomy/Debridement and/or Acromioplasty:

Criteria for subacromial decompression for subacromial impingement syndrome (80% improve without surgery.) Not recommended as an isolated procedure.

1. Conservative Care: Recommend at least 1 year unless meets earlier surgical criteria for other associated shoulder diagnoses: Physical therapy combined with home exercise, NSAIDs, corticosteroid injection, and taping are beneficial. Treatment must be directed toward gaining full motion with stretching and strengthening to re-balance shoulder musculature. PLUS

2. Subjective Clinical Findings: Significant functional impairment persisting at least 1 year. AND Pain with active arc motion between 90-130 degrees. AND Pain at night. PLUS

3. Objective Clinical Findings: Tenderness over rotator cuff or anterior acromial area. AND Positive impingement signs. 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 (subacromial bursitis, rotator cuff tendinosis, Type II or III acromion).