

US Decisions Inc.

An Independent Review Organization

8760 A Research Blvd #512

Austin, TX 78758

Phone: (512) 782-4560

Fax: (512) 870-8452

Email: manager@us-decisions.com

02/14/2018

Description of the service or services in dispute:

29806-22 – Left Shoulder Arthroscopy, surgical capsulorrhaphy

29822 – Arthroscopy shoulder surgery debridement, limited

29806 - Left shoulder arthroscopic posterior labral repair, debridement

(Authorization request shows: Request -Left Shoulder Arthroscopic Revision Posterior Labral Repair and Debridement; and Dx: S43.022D, S43.012D, S46.122D: Left shoulder posterior subluxation, anterior subluxation, laceration of bicep head)

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

Board Certified Orthopedic Surgery

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)

XXXX is a XX-year-old XX, who was diagnosed with posterior subluxation of left humerus, subsequent encounter. (S43.022D); left superior glenoid labrum lesion of left shoulder, subsequent encounter; and left anterior subluxation of left humerus, subsequent encounter.

Per utilization review report dated XXXX, XXXX sustained a work-related injury on XXXX, while XX was XXXX and felt a pop in XX upper arm. The diagnoses were laceration of muscle, fascia and tendon of long head of biceps, left arm, initial encounter (S46.122A); encounter for other specified surgical aftercare, (Z48.89); anterior subluxation of left humerus, subsequent encounter (S43.012D); Laceration of muscle, fascia and tendon of long head of biceps, left arm, subsequent encounter; (S46.122D) and posterior subluxation of left humerus, subsequent encounter, (S43.022D).

On XXXX, XXXX was evaluated by XXXX. Per report, XX had an anterior labral repair dated XXXX, which was healed, but XX had a new injury. On examination, the left shoulder active range of motion was 15 degrees extension, 103 degrees flexion, 21 degrees internal rotation, 76 degrees abduction, 24 degrees adduction and 17 degrees external rotation. The left-sided active and passive ranges of motion were restricted due to pain. There was decreased biceps reflex at 2/4. The apprehension, inferior sulcus sign, jerk test and posterior drawer tests were positive on the left side.

Treatment to date consisted of anterior labral repair, debridement, open biceps tendon tenodesis on XXXX, intra-articular injections, medications and physical therapy for eight months.

An MR arthrogram of the left shoulder dated XXXX revealed postero-superior labral tear, anteroinferior labral tear, resolution of paralabral cyst, mild supraspinatus tendinosis, greatly improved since the prior study and biceps tenodesis. X-rays of the left shoulder dated XXXX showed mild acromioclavicular and glenohumeral joint arthritis and bone screw tracts in the proximal humerus and inferior glenoid. The additional documentation available includes a progress note dated XXXX indicating that intra-articular corticosteroid injection was provided.

Per utilization review determination letter dated XXXX by XXXX (Orthopedic surgery), the request for left shoulder arthroscopic revision posterior labral repair and debridement was denied. Based on the clinical information submitted for the review, the findings were limited to confirm labrum deficits. Additionally, the objective findings presented were limited to show evidence of activity limitations significant enough to justify revision of surgery at the time. The recent MRI findings also did not show evidence of posterior labral tear or that there were isolated Type II or IV lesions to warrant direct repair or debridement for type I and III lesions. In addition, there was no objective documentation of failure from post-surgical physical therapy as there were noted improvement in range of motion and muscle strength post-surgical physical therapy notes were submitted. Given those findings, the request for revision of left shoulder posterior labral repair and debridement was not supported.

A letter dated XXXX, by XXXX (Orthopedic Surgery) indicated that the reconsideration request was non-certified. Per the peer discussion, it was stated the patient had a history of an anterior labral repair. The provider stated during the rehabilitation for that repair, the patient reinjured XX shoulder. An MRI of the left shoulder from XXXX, showed a new labral tear, which certainly was not there during the arthroscopy. The patient had a lot more pain since the new tear. The patient had been in therapy for about five months, and the provider felt an injection would be an option. The patient's symptoms and MRI did not warrant surgical procedures at the time, and the patient had not been offered an injection which could be therapeutic and diagnostic, therefore, the request must remain not medically necessary.

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

The clinical documentation available includes a progress note after the two prior utilization reviews indicating that an intra-articular corticosteroid injection was provided for both diagnostic and therapeutic management. The information available indicates that since the prior surgical intervention, the injured worker has tried and failed both physical therapy, analgesics, and activity modification. Significant persistent deficits are noted on recent examinations, including diminished range of motion. The new imaging reveals a posterior superior labral tear, and while a prior biceps tenodesis has been performed, this pathology could account for the persistent shoulder complaints. While the two initial reviews were correcting in indicating that further conservative measures were available, conservative measures have since been exhausted, and the proposed labral repair and debridement would be considered medically necessary; however, the capsulorrhaphy would not be supported as there is no indication of significant shoulder instability that would necessitate this procedure.

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

- 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
- 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

ODG 2018: Shoulder

Surgery for SLAP lesions

Recommended for some isolated, persistently symptomatic Type II lesions, and for Type IV lesions involving more than 50% of the biceps tendon. See SLAP lesion diagnosis for a discussion of frequent misdiagnosis and over-treatment related to high incidence of normal variants (either anterior sublabral recess, or a Buford complex), poor correlation of physical exam with pathology, and limitations of imaging studies.

See also Biceps tenodesis.

Criteria for Surgery for SLAP lesions:

- After 3 months of conservative treatment (NSAIDs, injection and PT) with symptoms and/or activity limitations significant enough to justify surgery.
- History, physical examination and imaging (which can only accurately rule out) indicate high likelihood of SLAP tear (beware confusion with anterior sublabral recess or Buford complex in up to 25% of the population); review by musculoskeletal radiologist can increase accuracy of diagnosis.
- Definitive diagnosis of SLAP lesions is only by diagnostic arthroscopy.

Direct Repair:

- Isolated Type II lesions (detachment of superior labrum).
- Isolated Type IV lesions (more than 50% of the tendon is involved, vertical tear, bucket-handle tear of the superior labrum, which extends into biceps, intrasubstance tear).
- Age < 35 (otherwise consider biceps tenodesis)
- Avoid direct repair for revision SLAP surgery and with associated large rotator cuff repair (biceps tenotomy preferred).
- Worse outcomes with direct repair can be anticipated for overhead throwers and injured workers.
- SLAP repair with simultaneous anterior/anterior-inferior, or posterior/posterior-inferior labral repair; with documentation of prior dislocation(s) or clear instability on exam and correlating imaging.

Biceps Tenodesis:

- Age over 35 (younger optional if overhead throwing athlete)
- Option for revision SLAP surgery or in combination with rotator cuff repair in younger (< age 55) individuals and those avoiding mild cosmetic deformity.

Biceps Tenotomy:

- Preferred for revision SLAP surgery, and with associated large rotator cuff repair, and for older (55 or above) patients.

Debridement:

- Generally, type I and type III lesions do not need any treatment or can be lightly debrided if other arthroscopic shoulder procedures are indicated.

Surgery for shoulder dislocation

Recommended as indicated below. External rotation bracing and thermal or laser capsulorrhaphy is specifically Not Recommended.

See also Surgery for AC joint (arthritis, separation).

ODG Indications for Surgery™ -- Shoulder (gleno-humeral) dislocation surgery:

Criteria for capsulorrhaphy, Bankart, and/or additional procedures for diagnosis of recurrent anterior dislocation, and more rarely for posterior dislocation, persistent recurrent subluxation, or multi-directional instability (MDI) failing physical therapy. Acute surgery (without therapy) is indicated for males under age 30 with highly demanding sports or job requirements (heavy contact or overhead), and all patients with early frequent re-dislocations or irreducible dislocations.

Best evidence considering complication rates and return-to work/play favors arthroscopic over open surgical techniques (e.g. arthroscopic Bankart, arthroscopic Bankart+remplissage; Latarjet and bone graft procedures are best reserved for revisions or large “bipolar” bony defects).

1. Subjective Clinical Findings: History of multiple dislocations or chronic instability disrupting activities of daily living. PLUS
2. Objective Clinical Findings: At least one of the following: Positive provocative tests (apprehension, relocation, load and shift). OR Humeral head defect (Hill Sachs). OR Dislocation/subluxation under anesthesia. PLUS
3. Imaging Clinical Findings: Conventional x-rays (AP and true lateral or axillary views), CT or MRI (with or without intra-articular contrast) consistent with recurrent dislocation/instability. AND Absence of recent non- or minimally-displaced greater tuberosity fracture. PLUS
4. Conservative Treatment failure: At least 3 months, including post-immobilization avoidance of vigorous sports and overhead work.

- 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)