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Description of the service or services in dispute:
- Right Shoulder Arthroscopy Rotator Cuff Repair
- Right Shoulder Arthroscopy with surgical decompression of subacromial space;
- Right Shoulder Arthroscopy; Repair Biceps tendon

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 XXXX who was diagnosed with incomplete rotator cuff tear or rupture of right shoulder not specified as traumatic, bicipital tendinitis of the right shoulder, superior glenoid labrum lesion of the right shoulder and pain in the right shoulder.

The patient had sustained an injury on XXXXX. XXXX was XXXX. XXXX had immediate pain. Since that time, the patient continued to have pain with slightly improving range of motion.

XXXX, evaluated XXXX. XXXX on XXXX. XXXX presented for a review of shoulder MRI and XXXX ongoing complaints. XXXX reported intermittent shoulder pain, rated as 4/10. The pain was increased by activity and was decreased by heat and ice. The right shoulder examination revealed tenderness on palpation at the biceps tendon, positive O'Brien's test and positive apprehension relocation test. There was increased pain with anterior load shift.

The prior treatments included medications, use of a brace, physical therapy and arthroscopic right knee surgery.

An MRI of the right shoulder dated XXXX revealed superior labral tear extending from the 10:00 to 1:00 position. The tear also extended to the biceps labral anchor with tendinosis of the intra-articular long head biceps tendon. The tiny foot plate tear of the supraspinatus was noted as well, involving the mid-substance fibers, which involved less than 50% of the overall thickness.

Per a utilization review dated XXXX by XXXX, the requested service was denied. The submitted medical records had been reviewed. The clinical findings, physical examination and treatment to date did meet the ODG guidelines. The requested service was not medically necessary or appropriate.

Per a utilization review letter dated XXXX by XXXX, the requested service was denied. The primary reason for determination included the service was not medically necessary or appropriate. The submitted medical records did not reveal shoulder weakness. There were no evidence of impingement signs. Although, the ODG supports treatment of biceps tendinosis and an associated labral tear, a successful peer conversation did not occur to modify the request. As such, the requested right shoulder arthroscopy, repair biceps tendon was not medically necessary. Therefore, the prior decision was upheld.

Additional Records
XXXX is a XX-year-old XXXX who was diagnosed with incomplete rotator cuff tear or rupture of right shoulder not specified as traumatic, bicipital tendinitis of the right shoulder, superior glenoid labrum lesion of the right shoulder and pain in the right shoulder.

The patient had sustained an injury on XXXX was XXXX. XXXX had immediate pain. Since that time, the patient continued to have pain with slightly improving range of motion.

Per an initial evaluation report dated XXXX, the patient was evaluated by XXXX. The patient had a new injury to XXXX right shoulder. There was decreased range of motion at abduction and extension. XXXX reported numbness and tingling in the upper extremities. Shoulder examination showed there was anterior tenderness. The shoulder range of motion on abduction and flexion was 15 degrees. Muscular weakness was noted at the supraspinatus, infraspinatus teres minor and subscapularis muscles. Extremity edema was noted. Impingement test was positive. Flexeril was prescribed. XXXX was recommended physical therapy.

XXXX, evaluated XXXX. XXXX on XXXX. XXXX presented for a review of shoulder MRI and XXXX ongoing complaints. XXXX reported intermittent shoulder pain, rated as 4/10. The pain was increased by activity and was decreased by heat and ice. The right shoulder examination revealed tenderness on palpation at the biceps tendon, positive O'Brien's test and positive apprehension relocation test. There was increased pain with anterior load shift.

A DWC-Form 73 by XXXX dated XXXX, the patient was injured while XXXX. XXXX experienced popping in XXXX right shoulder. XXXX could return to work as of XXXXX with restrictions included no use of the right arm and no lifting/carrying more than 10 pounds for more than eight hours per day, which were expected to last through XXXX.

The prior treatments included medications, use of a brace and physical therapy.

X-rays of the right shoulder dated XXXX revealed negative right shoulder. An MRI of the right shoulder dated XXXX showed small interstitial partial-thickness tear of the distal supraspinatus tendon. There was osteoarthritis including moderate acromioclavicular osteoarthritis. An MRI of the right shoulder dated XXXX revealed superior labral tear extending from the 10 o’clock to 1 o’clock position. The tear also extended to the biceps labral anchor with tendinosis of the intra-articular long head biceps tendon. The tiny foot plate tear of the supraspinatus was noted as well, involving the mid-substance fibers, which involved less than 50% of the overall thickness.

Per a utilization review dated XXXX by XXXX, the requested service was denied. The submitted medical records had been reviewed. The clinical findings, physical examination and treatment to date did not meet the ODG guidelines. The requested service was not medically necessary or appropriate.

Per a utilization review letter dated XXXX by XXXX, the requested service was denied. The primary reason for determination included the service was not medically necessary or appropriate. The submitted medical records did not reveal shoulder weakness. There were no evidence of impingement signs. Although the ODG supports treatment of biceps tendinosis and an associated labral tear, a successful peer conversation did not occur to modify the request. As such, the requested right shoulder arthroscopy, repair biceps tendon was not medically necessary. Therefore, the prior decision was upheld.

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

The opinion provided by the second reviewer is correct that the biceps tenodesis would be indicated given the clear evidence of labral pathology involving the biceps tendon anchor. Additionally, the second reviewer was also correct in asserting that the subacromial decompression and rotator cuff repair would not be warranted based on information available. The provider clearly indicates negative signs of impingement and there is no evidence of significant rotator cuff weakness that would necessitate repair for this partial thickness tear. Partial certification for the biceps tenodesis alone is advised.

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

☑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

Official Disability Guidelines® (22nd annual edition) & ODG® Treatment in Workers' Comp (15th annual edition) Shoulder Chapter

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).

☐ 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)