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Description of the service or services in dispute:

Left shoulder arthroscopic inferior labral repair versus capsular repair, possible rotator cuff repair, debridement

Description of the qualifications for each physician or other health care provider who reviewed the decision: Board Certified 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, XXXX, who was diagnosed with an inferior subluxation of left humerus and incomplete tear of the rotator cuff. The patient sustained an injury on XXXX when XXXX was XXXX. XXXX was in a tight spot and awkward position and when the XXXX, XXXX felt immediate pain in the left shoulder.

Per a note by XXXX, dated XXXX, the patient had presented for a follow-up of XXXX left shoulder pain, which XXXX stated was worse. XXXX noted that the injections had not helped. Examination of the left shoulder revealed atrophy over the left rotator cuff and tenderness of the left shoulder. Active range of motion was 20 degrees extension, 110 degrees flexion, 20 degrees internal rotation, 120 degrees abduction and 30 degrees adduction and external rotation. There was a painful arc on 90 to 130 degrees passive range of motion. Left shoulder strength was 4/5 in left shoulder flexion, extension, abduction, adduction, external rotation, internal rotation; and biceps and triceps reflexes of 2/4. The left shoulder demonstrated guarded empty can and drop arm tests along with positive Neer's, Hawkins, Yocum's, O'Brien's, crank and biceps load tests. XXXX documented that the patient had failed to improve since XXXX.

Treatment to date consisted of medications, intra-articular injection (no help) and physical therapy (goals not met).

A left shoulder x-ray performed on XXXX revealed a normal examination. An MR arthrogram of the left shoulder dated XXXX, revealed mild supraspinatus tendinosis with 2.5 mm anterior articular surface footplate tear; unusual tear at the junction of the inferior labrum and cartilage; a small linear strand

identified in the posteroinferior shoulder joint recess, which was most likely secondary to a partial tear of the posterior band of the inferior glenohumeral ligament.
Per a utilization review determination letter dated XXX by XXXX, (Orthopedic Surgery), the initial request for left shoulder arthroscopic inferior labral repair versus capsular repair, possible rotator cuff repair with debridement was non-certified. It was determined that the patient was a good candidate for the surgery; however, there were no conventional x-rays of anterior-posterior, true lateral or axillary views that needed to be submitted together with the MRI. Pending this information, the request was not established.

Per a reconsideration review letter dated XXXX by XXXX, (Orthopedic Surgery), the reconsideration request for left shoulder arthroscopic inferior labral repair versus capsular repair, possible rotator cuff repair with debridement was non-certified. Rationale: Objective findings were limited as there was no documented weakness with abduction testing but demonstrated atrophy of shoulder musculature. Furthermore, exhaustion of lower level of care was not established, as the patient only had eight physical therapy sessions with improvement in the range of motion. Thus, the request was not supported.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision. The clinical documentation available indicates that this XXXX has undergone at least XXXX of conservative treatment to include medications, injections, and physical therapy. Physical therapy goals are not met, range of motion remains significantly limited, and there is weakness on examination. Provocative orthopedic maneuvers remain positive, and the MR arthrogram is sufficient to identify the pathology that would warrant operative intervention. Given the current objective findings and evidence of prior imaging, the requested surgical intervention would be considered medically necessary, particularly when noting the PASTA (partial articular supraspinatus tendon avulsion) lesion. Recommendation is made for overturning the prior denial and certifying the proposed operative 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 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
Shoulder Chapter

☐ 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)