CASEREVIEW

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IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left shoulder arthroscopy with debridement, rotator cuff repair and biceps tenodesis

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Certified Orthopedic Surgeon with over 18 years of experience.

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is XXXX who sustained a rotator cuff injury of the left shoulder on XX. XX underwent rotator cuff repair on XX. XX has had XX, physical therapy, rest and surgery.

On XX, Left shoulder CT Impression: The mildly displaced distal left clavicle fracture is redemonstrated, now with mild periosteal callus formation but no appreciable bridging bone. The fracture margins are partially corticated and there is mild bony resorption compared to prior study.

On XX, the claimant presented to XX, MD post-op left shoulder arthroscopy, subacromial decompression, debridement of partial thickness rotator cuff tear and distal clavicle excision on XX. XX continued to have significant pain. XX reported numbness into XX hand. XX was unable to progress in therapy due to the pain. XX has had two previous steroid injections with no improvement. XX continued to have pain in the left subacromial space which was made worse with activity and relieved with rest. On examination there was mild tenderness at the A/C joint and biceps tendon. Shoulder ROM was normal. Shoulder strength was slightly decreased. Plan: It was recommended that XX massage the bump over the clavicle with vitamin E cream. XX was given another steroid injection and recommended to try more PT. If no improvement, MRI.

On XX the claimant presented to XX, MD with continued pain and stiffness in the shoulder. XX reported it traveled through the neck. XX also had tenderness over the A.C. joint. XX felt some nodules around the joint. XX had good ROM, but felt like there was swelling in XX bursa. On exam there was slightly decrease of ROM. Elevation strength and external rotation strength was slightly decreased. Plan: Redo MRI. Voltaren cream was prescribed. Considered repeat injection.

On XX, the claimant presented to XX, MD with continued pain and aching pain radiating down through the arm. XX had reasonable ROM. XX had pain in the subacromial bursa with elevation of the arm. XX also had pain at night. Plan: It was recommended to give XX shoulder a little more time (XX). If no progress then surgery. Recommended to start with another steroid injection and if XX returns with increased pain, the move forward with surgery.

On XX, Arthrogram and postarthrogram MRI of the left shoulder Impression: Distal supraspinatus tendon insertional partial tar with mild underlying humeral marrow edema and associated moderate tendiosis. Mild to moderate infraspinatus tendinosis. Moderate subdeltoid bursitis. Postop AC joint.

On XX, XX MD performed a UR. Rationale for Denial: When considering the date of injury, noting the prior surgery completed, tempered by the most recent of physical examination findings reported, there is no specific clinical data presented suggesting a need for additional shoulder arthroscopy. Therefore, this is not clinically indicated and recommended for non-certification.

On XX, XX MD performed a UR. Rationale for Denial: Based on the medical records it does not appear the request for 1 left shoulder arthroscopy with debridement, rotator cuff repair and biceps tenodesis is warranted. An MRI report of the shoulder on XX revealed the long head biceps tendon anchor is intact. There was no joint effusion and the labrum was described as diminutive. A partial tear of the supraspinatus and infraspinatus was identified. An arthrogram was performed, fatty infiltrate on the musculature was identified, and there were degenerative changes to the supraspinatus. The medical records do not indicate any significant shoulder pathology. The claimant is noted to have pain and slightly reduced shoulder range of motion. No specific range of motion findings are provided in the progress notes. The claimant is not noted to demonstrate pain with active arc motion from 90-130 degrees, weakness, or atrophy. There is no clinical indication of shoulder impingement. As XX noted, there is no specific clinical data presented suggesting the need for additional shoulder arthroscopy.

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

The request for left shoulder arthroscopy with debridement, rotator cuff repair and biceps tenodesis is not medically necessary and therefore, is denied.

The patient is a XX who underwent left shoulder arthroscopy on XX. XX continues to have pain in the left shoulder, despite steroid injections and physical therapy. On examination, the patient has “reasonable” range of motion of the shoulder. The post-op MR-arthrogram of XX demonstrated a partial tear of the distal supraspinatus (40-50% thickness). The posterior superior labrum had degenerative features, without any pathology identified in the biceps tendon. The treating physician has recommended repeat arthroscopy of the shoulder with debridement, rotator cuff repair and biceps tenodesis.

The Official Disability Guidelines (ODG) supports rotator cuff repair for small full thickness and partial thickness rotator cuff tears in patients who have failed XX of conservative care with subjective and objective clinical findings. Subjective clinical findings include pain in the arc of motion 90 to 130 degrees as well as night pain. Weak or absent abduction should be documented, in addition to a positive impingement sign and temporary relief following XX injection. Rotator cuff pathology should be identified on MRI.

The ODG supports biceps tenodesis in patients with a history, examination and imaging studies consistent with biceps tendon pathology or rupture.

This patient does not have objective and subjective findings to satisfy the ODG indications for rotator cuff repair. There is insufficient documentation to support the medical necessity for biceps tenodesis.

PER ODG:

ODG Indications for Surgery™ -- Rotator cuff repair:
Criteria for rotator cuff repair with diagnosis of moderate to large full-thickness rotator cuff tear AND cervical pathology and frozen shoulder syndrome have been ruled out:
1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS
2. Objective Clinical Findings: Weakness with abduction/external rotation testing. May also have mild atrophy of shoulder musculature. Should have full passive range of motion. PLUS
3. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary views AND MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff without significant fatty infiltration (atrophy).
Criteria for rotator cuff repair AND/OR anterior acromioplasty with diagnosis of small full-thickness or partial-thickness rotator cuff tear OR acromial impingement syndrome (80% of these patients will get better without surgery.)
1. Conservative Care: Recommend 3 to 6 months: Three months is generally adequate if treatment has been continuous, six months if treatment has been intermittent. Exercise must be directed toward gaining full ROM, with both stretching and strengthening to balance muscles. Earlier surgical intervention may be required with failure to progress with therapy, high pain levels, and/or mechanical catching. PLUS
2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS
3. Objective Clinical Findings: Weak or absent abduction; may also have mild atrophy of shoulder musculature, AND Tenderness over rotator cuff, greater tuberosity, 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 views AND MRI, ultrasound, or arthrogram shows positive evidence of at least partial deficit in rotator cuff without significant fatty infiltration (atrophy).
For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

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 (XX, 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)

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**
- ☐ **AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**