

Applied Independent Review
An Independent Review Organization

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Review Outcome:

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

Orthopaedic Surgery
Hand Surgery

Description of the service or services in dispute:

Right shoulder arthroscopy with rotator cuff repair if possible or possible superior capsular reconstruction if the tear is repairable

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

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

Patient Clinical History (Summary)

This case involves a now XX XX with a history of an occupational claim from XX. XX was injured as a result of stepping from XX XX truck, when XX slipped and fell onto XX right arm and shoulder. XX was diagnosed with rotator cuff tear of the right shoulder. An MRI of the right shoulder performed on XX revealed a full-thickness tear and retraction of the supraspinatus and infraspinatus tendons, mild tendinosis of the distal intact subscapularis tendon, mild to moderate blunting of the entire labrum, severe proximal biceps tendinopathy, moderate humeral and mild glenoid chondromalacia, superior subluxation of the humeral head, severe hypertrophy of the acromial clavicular joint causing impingement, and bursitis. On XX, the patient presented for follow-up with persistent pain in the shoulder. XX had been participating in physical therapy. The pain was localized to the anterior right shoulder and exacerbated with certain movements such as lifting the arm. A subacromial injection was performed with corticosteroid and local anesthetic, although the patient reported no relief on XX. XX continued to complain of pain and weakness with difficulty lifting the right upper extremity. The request was submitted for surgical rotator cuff repair or capsular reconstruction. However, this request was not found to be not entirely supported, as guidelines to support rotator cuff repair but not superior capsular reconstruction.

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

According to the Official Disability Guidelines, rotator cuff repair is recommended for patients who have

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Notice of Independent Review Decision

Case Number: XXXX

Date of Notice: 07/18/2018

imaging findings indicative of rotator cuff tears, and who have positive subjective and objective complaints. Patients should also have failed non-operative modalities prior to the consideration for surgery. Guidelines indicate that superior capsular reconstruction is not recommended by guidelines, as there are a lack of quality studies to support efficacy. In this case, the request was submitted for right shoulder arthroscopy with rotator cuff repair if possible, or possible superior capsular reconstruction. According to the available documentation, the patient had a full-thickness tear and retraction of the supraspinatus and infraspinatus confirmed by the MRI, with difficulty elevating the arm. There is persistent pain, limited range of motion, and a failure to respond to injections as well as therapy and other non-operative treatments. However, the request was previously denied as the request was submitted for right shoulder rotator cuff repair or possible superior capsular reconstruction, depending on the status of the rotator cuff during surgery. The patient meets guideline criteria for a rotator cuff repair, but not a superior capsular reconstruction, as guidelines indicate that this treatment modality is not supported due to insufficient evidence. Given the state of jurisdiction, a partial approval cannot be given without peer-to-peer discussion. As such, the request for 'Right shoulder arthroscopy with rotator cuff repair if possible, or possible superior capsular reconstruction if the tear is repairable' is not medically necessary, and the prior determination is upheld.

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 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)