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Description of the service or services in dispute:
23472 – Left shoulder reverse total shoulder arthroscopy
L3962 – Shoulder abduction sling with pillow
Inpatient stay

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)

☐ Upheld (Agree)

☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)
XXXX is a XXXX who was diagnosed with left shoulder osteoarthritis (M19.012) and left shoulder chronic rotator cuff tendon tear (M75.122).

On XXXX, the patient XXXX when XXXX was trying to XXXX. XXXX landed on the left shoulder. Upon further questioning of the patient, XXXX stated that XXXX actually hurt XXXX shoulder initially XXXX prior while XXXX was working.

The patient was seen on XXXX by XXXX for a follow-up regarding XXXX left shoulder pain and weakness. On examination, left shoulder revealed a positive drop arm test, 3/5 strength with forward elevation and shoulder abduction, crepitus with internal and external rotation. The passive range of motion was full and unrestricted. XXXX was advised left reverse total shoulder arthroplasty.

Treatment to date included medications, corticosteroid injection (minimal relief for a very short period of time) and physical therapy (not beneficial).

An MRI of the left shoulder performed on XXXX revealed a full-thickness tear of the supraspinatus tendon, suspected partial thickness tear of the superior labrum, anterior and posterior, degenerative change at the acromioclavicular joint with mild shoulder impingement, shoulder joint effusion and subcoracoid bursitis. Plain x-rays from an unknown date revealed enthesopathic changes of the greater tuberosity, slight cephalad migration of the humeral head relative to the glenoid fossa and some mild sclerosis of the glenohumeral joint.

Per a Notification of Adverse Determination letter dated XXXX by XXXX, the requested services were non-certified. Rationale: “Per evidence-based guidelines, reverse total shoulder arthroplasty is

recommended for irreparable rotator cuff tears in patients with concordant subjective and objective findings after 6 months of conservative treatment (unless performed for acute fracture). The date of injury was late XXXX, per XXXX. The patient does have persistent symptoms and objective exam finding despite approximately four months of conservative care including rest, activity modification, physical therapy and injection. The guidelines do recommend six months of conservative care though. Per XXXX, the patient was XXXX but there was no clear evidence that there was a significant weight loss effort for body mass index above XXXX. Thus, the request is not supported at this time. The concurrently requested surgery is not established which precludes the need for shoulder abduction sling with pillow and inpatient stay. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There is incomplete conservative care (based on the guidelines) and the documentation does not address weight loss (the patient has a Body mass index greater than XXXX)."

Per a Notification of Adverse Determination letter dated XXXX by XXXX, the requested services were non-certified. Rationale: "Per evidence-based guidelines, reverse total shoulder arthroplasty is recommended for irreparable rotator cuff tears in patients with concordant subjective and objective finding after 6 months of conservative treatment. The patient was recommended reverse total shoulder arthroplasty. However, there was limited documentation on the medicals that the patient had exhausted all conservative treatment before suggesting surgery. In addition, the objective clinical findings were insufficient to support the requested treatment per guideline recommendation. The previous determination is still upheld. Thus, the request is not supported. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There was limited documentation on the medicals that the patient had exhausted all conservative treatment before suggesting surgery. In addition, the objective clinical findings were insufficient to support the requested treatment per guideline recommendation. The previous determination is still upheld. Thus, the request is not supported."

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

The ODG supports the use of total shoulder arthroplasty as an option for nonfunctioning repairable rotator cuffs--with or without glenohumeral arthropathy--when there is documentation of limited functional demands, intractable pain, adequate deltoid function, adequate passive range of motion, residual bone permits fixation, no evidence of infection, no severe neurologic deficiency, and BMI less than 40 with a documented significant weight loss effort for BMI greater than 35. Based on the clinical documentation provided, the injured worker had already undergone four months of conservative management for the chronic full thickness supraspinatus tendon tear with superior migration of the humeral head. Treatment included physical therapy and corticosteroid injections. Three ODG criteria have not been met including duration of conservative treatment, trial of NSAIDs, and documented attempts at weight loss. With regard to the trial of NSAIDs, given the chronic rotator cuff tear and reported functional deficits, oral NSAIDs would not address the functional deficits. While pain may improve, the deficits would remain. As such, this would not preclude proceeding with shoulder arthroplasty. Regarding the duration of conservative treatment, it is unlikely that any additional physical or occupational therapy or a repeat injection will result in significant objective functional improvement. Regarding the weight loss, the patient was noted to be XXXX, for a BMI of XXXX. For the BMI criteria to be met, the patient would need to lose approximately XXXX. It is highly unlikely that this difference of XXXX would change the surgical outcome. As such, slight deviation from the ODG criteria would be warranted, and the proposed procedure is considered medically necessary.

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
ODG, 2018: shoulder

Reverse shoulder arthroplasty (RSA)
Recommended as indicated below.

See also Arthroplasty (shoulder); Arthroscopic debridement (for shoulder arthritis); and Surgery for rotator cuff repair. For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

ODG Indications for Surgery™ -- Reverse Shoulder Arthroplasty:
Technical considerations include concepts of newer implant designs incorporating lateral offset, 135-degree humeral cup inclination, and larger glenospheres, with or without bone cement.
• Non-functioning irreparable rotator cuff with or without gleno-humeral arthropathy (arthritis); OR
• Rheumatoid arthritis with rotator cuff deficiency. OR
• Failed hemiarthroplasty or failed total shoulder arthroplasty with irreparable rotator cuff deficiency; OR
• Comminuted, displaced fractures (3 or 4 part) of the proximal humerus in older population (65 years or more). &
• Meets all of the following criteria:
- Limited functional demands; &
- Intractable pain that has not responded to conservative therapy (including NSAIDs, intra-articular steroid injections, and physical therapy) for at least 6 months, unless acute fracture; &
- Adequate deltoid function; &
- Adequate passive range of motion to obtain functional benefit from the prosthetics; &
- Residual bone permits firm fixation of the implants; &
- No evidence of shoulder infection; &
- No severe neurologic deficiency; &
- Body Mass Index less than 40, with documented significant weight loss effort for BMI>35, unless acute fracture; &
- If rheumatoid arthritis, tried and failed anti-cytokine agents or disease modifying anti-rheumatic drugs, unless acute fracture.

Risk versus benefit: Historical overall complication rates were as high as 25% (only 5% major) with primary RSA but up to 69% for revision RSA. (Saltzman, 2014) RSA compared with TSA has significantly longer length of stay and higher hospital charges (not completely attributable to increased implant costs alone), as well as increased perioperative complications. (Jiang, 2014) Early RSA revision (dislocation most common), is associated with age under 65, smoking, and obesity. (Werner, 2015) Younger age, high pre-operative function, and neurologic dysfunction were associated with poorer functional improvement following RSA for massive rotator cuff tears without arthritis. (Hartzler, 2015) While rotator cuff tear arthropathy patients with RSA often had restoration of pain-free range-of-motion and improved function, a 17.4% complication rate including heterotopic ossification (HO) (6.6%), and

7.3% revision rate can be expected. (Petrillo, 2017) HO has been reported in up to 30% of RSA patients, being generally non-progressive, but grade II HO occurs in 11% with some negative effects on shoulder function. (Verhofste, 2016) RSA for fracture sequelae (malunion, nonunion) particularly carries much higher risks of significant complications including dislocation (17%), infection (7%), fracture (3%), and neurological injury (3%). (Holton, 2017) Due to higher surgical failures for more complex conditions including implant revisions, RSA should be very cautiously considered for strictest indications only. Compared to other total joint arthroplasties there is reported to still be a steep surgical learning curve as well as relatively poor revision options.

☐ 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)

J Shoulder Elbow Surg. 2017 Sep;26(9):e265-e277. doi: 10.1016/j.jse.2017.03.039. Epub 2017 Jul 3.
Reverse shoulder arthroplasty for irreparable massive rotator cuff tears: a systematic review with meta-analysis and meta-regression.
Sevivas N1, Ferreira N2, Andrade R3, Moreira P4, Portugal R5, Alves D4, Vieira da Silva M6, Sousa N4, Salgado AJ4, Espregueira-Mendes J7.

Musculoskeletal Surg. 2017 Aug;101(2):105-112. doi: 10.1007/s12306-017-0474-z. Epub 2017 Apr 25.
Reverse shoulder arthroplasty for massive irreparable rotator cuff tears and cuff tear arthropathy: a systematic review.
Petrillo S1,2, Longo UG3,4, Papalia R3,4, Denaro V3,4.

☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.