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An Independent Review Organization

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June 11, 2018

Description of the service or services in dispute: 29807 - Arthroscopy, surgical repair of a superior labrum anterior/posterior (SLAP) lesion of the left shoulder

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) XXXX who was diagnosed with superior glenoid labrum lesion of the left shoulder and adhesive capsulitis of the left shoulder.

On XXXX, XXXX had left shoulder pain after XXXX. XXXX felt a pop in the anterior aspect of the left shoulder. XXXX also noticed left shoulder numbness / tingling sensation at the time.

On XXXX, XXXX was seen by XXXX for left shoulder pain. XXXX reported XXXX had left rotator cuff tendinitis, and the condition remained unchanged. On examination of the left shoulder, there were old surgical scars. The active range of motion was normal, flexion had moderate-to-severe pain at 90 degrees, abduction had moderate-to-severe pain at 90 degrees, adduction was normal (0 to 50 degrees), internal rotation was to S1, and external rotation had moderate-to-severe pain at 45 degrees. The muscle strength was +4/5 at the external rotators, internal rotators and supraspinatus. XXXX had positive cross shoulder adduction with positive impingement sign and positive O'Brien's test. The assessment was superior glenoid labrum lesion of the left shoulder. Arthroscopy of the left shoulder with repair of superior labrum anterior / posterior (SLAP) lesion was scheduled.

A utilization review (Physician Advisor Report) dated XXXX by XXXX, indicated that the requested service was denied. The rationale was, "Regarding left shoulder with repair of superior labrum anterior/posterior (SLAP) lesion, lysis of adhesions with / without manipulation, assistant surgeon, general anesthesia and antibiotic: Ancef 1 gram intravenous preoperative, this patient has ongoing complaints of pain in the left shoulder. Objectively, lateral examination revealed old surgical scars. The active range of motion (AROM) extension is normal. There is moderate-to-severe pain with flexion at 90 degrees, abduction with pain at 30 degrees, adduction 100 degrees, internal rotation to S1 and external rotation with pain at 45 degrees. There are positive cross shoulder abduction and positive impingement signs. While the patient may need surgical intervention, the guideline criteria have not been met. ODG guidelines recommend an assistant surgeon for more complex cases. In this case, there is no discussion why an assistant surgeon would be required. In addition, a clear treatment plan in regards to with / without manipulation has not been provided. Being a XX and inability to provide a

modified treatment plan, the request has not been substantiated in its entirety. Recommend non-certification.”

A reconsideration review (Physician Advisor Report) dated XXXX, indicated that the requested service was denied. The rationale was, “The request was previously denied as a rationale for with / without manipulation was not provided. The clinical documentation submitted for review indicated this patient had left shoulder pain with significantly restricted range of motion and motor strength despite multiple modalities of conservative care. Positive provocative test findings were documented. However, while pathology was noted, direct SLAP repair is not recommended in those XX of age and surgery for adhesive capsulitis (to included manipulation) is under study. Consequently, the request is not supported. As such, the requested left arthroscopy SLAP repair, lysis of adhesions with / without manipulation is non-certified. Recommend non-certification for left shoulder arthroscopy SLAP repair, lysis of adhesions with / without manipulation. The request was previously denied as the surgical procedure was not authorized. The clinical documentation for review still did not provide the necessary information to warrant the surgical procedure at this time. Consequently, the request is not supported. As such, the requested assistant surgeon is non-certified. Recommend non-certification for assistant surgeon. The request was previously denied as the surgical procedure was not authorized. The clinical documentation submitted for review still did not provide the necessary information to warrant the surgical procedure at this time. Consequently, the request is not supported. As such, the requested general anesthesia is non-certified. Recommend non-certification for general anesthesia. The request was previously denied as the surgical procedure was not authorized. The clinical documentation submitted for review still did not provide the necessary information to warrant the surgical procedure at this time. Consequently, the request is not supported. As such, the requested antibiotics XX 1 gram XX is non-certified. Recommend non-certification for antibiotics XX 1 gram XX Treatment to date included surgical intervention (acromioplasty), medications (XX, XX, XX, XX, XX, XX, XX, XX, XX, XX, XX, XX, XX, XX), injections (XX, aspiration and / or injection at the major joint or bursa with ultrasound guidance with no improvement) and physical therapy (without any improvement in the symptoms).

An MRI of the left shoulder dated XXXX showed an extensive labial tear with thickened inferior glenohumeral ligament that could be seen with adhesive capsulitis. There was prior acromioplasty with biceps tenodesis. Subacromial-subdeltoid bursitis was present.

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

The ODG supports the use of operative intervention as an option for the management of labral pathology. However, direct repair of a SLAP lesion is not supported by the ODG in individuals over XX due to the potential complications from the surgical intervention including stiffness (adhesive capsulitis). When noting that the injured worker already had issues with adhesive capsulitis and when noting that the patient is XXXX, it is unclear why a direct SLAP repair would be necessary. While there is a documented trial and failure of available conservative interventions, given the information provided, the submitted CPT code for surgical repair of superior labral lesion would not be supported by the ODG. A recommendation is made for upholding the original denials. Given the documentation available, the requested service(s) is considered not 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
- AHRQ-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and Guidelines
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- 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

Recommended for some isolated, persistently symptomatic Type II lesions, and for Type IV lesions involving more than 50% of the biceps tendon. See SLAP lesion diagnosis for a discussion of frequent misdiagnosis and over-treatment related to high incidence of normal variants (either anterior sub-labral recess, or a Buford complex), poor correlation of physical exam with pathology, and limitations of imaging studies.

Criteria for Surgery for SLAP lesions:

- *After 3 months of conservative treatment (NSAIDs, injection and PT) with symptoms and/or activity limitations significant enough to justify surgery.*
- *History, physical examination and imaging (which can only accurately rule out) indicate high likelihood of SLAP tear (beware confusion with anterior sub-labral recess or Buford complex in up to 25% of the population); review by musculoskeletal radiologist can increase accuracy of diagnosis.*
- *Definitive diagnosis of SLAP lesions is only by diagnostic arthroscopy.*

Direct Repair:

- *Isolated Type II lesions (detachment of superior labrum).*
- *Isolated Type IV lesions (more than 50% of the tendon is involved, vertical tear, bucket-handle tear of the superior labrum, which extends into biceps, intrasubstance tear).*
- *Age ≤ 35 (otherwise consider biceps tenodesis)*
- *Avoid direct repair for revision SLAP surgery and with associated large rotator cuff repair (biceps tenotomy preferred).*
- *Worse outcomes with direct repair can be anticipated for overhead throwers and injured workers.*
- *SLAP repair with simultaneous anterior/anterior-inferior, or posterior/posterior-inferior labral repair; with documentation of prior dislocation(s) or clear instability on exam and correlating imaging.*

Biceps Tenodesis:

- *Age over 35 (younger optional if overhead throwing athlete)*
- *Option for revision SLAP surgery or in combination with rotator cuff repair in younger (\leq age 55) individuals and those avoiding mild cosmetic deformity.*

Biceps Tenotomy:

- *Preferred for revision SLAP surgery, and with associated large rotator cuff repair, and for older (55 or above) patients.*

Debridement:

- *Generally, type I and type III lesions do not need any treatment or can be lightly debrided if other arthroscopic shoulder procedures are indicated.*

Risk versus benefit: *Direct arthroscopic repair of isolated SLAP tears has shown reasonably good outcomes for most carefully selected patients through the 4th decade, but results significantly worsen with increased age, in combination with other procedures (cuff repair), revision surgery and in injured workers. Biceps tenodesis or tenotomy has shown more predictable results for these potentially difficult*

patients who often develop adhesive capsulitis and persistent pain following direct repair. Poorer results have been specifically noted with all SLAP procedures in professional overhead throwers. Perhaps the biggest concern is the potential performance of unnecessary SLAP surgery due to misinterpretation of normal anatomic variants (either anterior sub-labral complex, or Buford complex), which can be found in over 25% of the population (versus only 1-2% actual incidence of Type 2 and 4 tears). The risk of outpatient arthroscopic surgery for SLAP tears is relatively low. The risk of not returning to former activity levels, stiffness and repair failure is relatively high for direct repair in the groups described above.

Although history, physical examinations and imaging modalities (MRI, MRA and CT) are important in ruling out SLAP (superior labrum anterior to posterior) tears, the definitive diagnosis of clinically significant SLAP lesions is accomplished only by arthroscopy. Generally, type I and type III lesions do not require any treatment or are occasionally debrided, whereas type II and some type IV lesions may require repair. (Nam, 2003) (Pujol, 2006) (Wheless, 2007) Outcomes in Worker's compensation patients are somewhat inferior. (Verma, 2007)

Recent research: Lower quality studies have continued to enthusiastically support surgical repair for selected patients. Arthroscopic repair of extensive tears can achieve good outcomes. (Huang, 2013) Good to excellent results were reported in 94% of patients, with no statistical correlation found between the patient age and gender with outcome scores. (Mok, 2012) Although rehabilitation may be affected by a protracted period of pain, long-term limitation of ROM after surgery is unlikely with the recommended anatomic restoration and repair of type II SLAP lesions. (Boesmueller, 2012) Long-term outcomes after isolated labral repair for SLAP lesions are generally good and independent of age. Satisfaction was rated excellent/good for 88% of patients at 5 years with postoperative stiffness reported at 13.1%. (Schröder, 2012)

Higher quality research has raised major questions regarding the effectiveness of SLAP repair, especially in certain subsets of patients. A prospective cohort of 179 SLAP repairs followed for 2-4 years showed general improvement but limited return to previous activity level. There was a 33% failure and 28% revision rate which was of concern, especially in patients over age 36. (Provencher, 2013) A systematic review of SLAP repair over age 40 demonstrated significantly higher failure rates with decreased patient satisfaction and increased complications in the older cohorts. Worse results were also noted in workers' compensation patients and those with associated rotator cuff tears. Since the literature demonstrates more reliable results for older patients with biceps tenotomy or tenodesis, these procedures should be favored over repair. Tenotomy is specifically recommended for revision SLAP surgery and with associated large rotator cuff tears. (Erickson, 2015) A direct comparison of isolated SLAP repairs vs. tenodesis in patients over XX a shorter recovery, more predictable functional outcome and higher satisfaction with tenodesis. (Denard, 2014) An 89% return to previous activity was reported with biceps tenodesis for type II/IV SLAP tears, with no age effect on outcomes. (Gottschalk, 2014) Attempts to combine SLAP repair with tenodesis for biceps tendonitis/SLAP resulted in significantly worse outcomes than either isolated repair or tenodesis, and should be avoided. (Chalmers, 2015) In a cohort study, combining SLAP repair with large rotator cuff repair was significantly inferior to tenotomy/cuff repair for both functional and range of motion outcomes. (Kim, 2012) Shoulder surgery for SLAP tears may not be successful for many patients. For example, of professional baseball pitchers who failed physical rehabilitation and then went on to surgery, only 7% were able to play as well as they had before, while for pitchers who only had physical rehabilitation, 22% were able to play as well as previously. (Fedoriw, 2012) Imaging studies following SLAP repairs have raised concern regarding long-term effectiveness and durability of this procedure. 43% of type II repairs appeared to have recurrent tears on MRA at 1 year, despite an 88% reported clinical success rate. (Trantalis, 2015) A 48% finding of suspicious superior labral clefts was observed with CTA following SLAP repair, but also did not correlate with clinical outcome. (Choi, 2015) While SLAP lesions that truly benefit from surgical

repair are relatively uncommon, there has been a substantial increase in the numbers of arthroscopic SLAP repairs, significantly more rapid than other outpatient orthopedic surgical procedures. In addition, there has been a significant increase in the age of patients who have been treated with arthroscopic SLAP repair. (Onyekwelu, 2012) In cases with SLAP lesions and concomitant anterior, or anterior-inferior labral tears and anterior instability, or concomitant posterior, or posterior-inferior labral tears with instability, repair of the anterior labrum for anterior instability, or the posterior labrum for posterior instability is recommended, with the SLAP lesion being repaired simultaneously. Instability means documented history of dislocation, or clear subluxability on physical exam with a correlating labrum tear on imaging. (Virk, 2013)

- 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)

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.