



**MEDICAL EVALUATORS
OF TEXAS ASO, LLC.**

2211 West 34th St. • Houston, TX 77018
800-845-8982 FAX: 713-583-5943

DATE OF REVIEW: March 5, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Denial of coverage for Left Shoulder Arthroscopy with Acromioplasty, Distal Clavicle Excision, Extensive Debridement, Capsular Release, Tenolysis, Loose Body Removal, Rotator Cuff Repair, Labral Repair, SLAP Repair, Biceps Tenodesis; 29827, 29828, 29807, 29826, 29824, 29823, and 29813

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This case was reviewed by a physician who holds a board certification in Orthopaedic Surgery and is currently licensed and practicing in the State of Texas.

REVIEW OUTCOME

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

Upheld

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The claimant is a **XXXX** who was injured on **XXXX** while **XXXX** when **XXXX** felt a pop with immediate onset of pain in **XXXX** left shoulder. MRI of the left shoulder performed **XXXX** revealed "1. Mild thickness articular sided partial tear anterior distal infraspinatus measures an estimated 9x6 mm, no fatty muscle atrophy. 2. Favor labral tearing in this nondistended joint to involve the posterior superior, posterior inferior, and inferior labral quadrants with a small paralabral cyst formation abutting the inferior glenoid. Probable additional posterior and anterior inferior labral tearing. Subtle cortical flattening of the posterior superior humeral head may be from a remote Hill-Sachs injury. Chondral thinning and irregularity with mild cortical irregularity inferior glenoid and to a lesser degree the adjacent anteromedial humeral head. 3. Mild subacromial/subdeltoid bursitis. 4. Diffuse mild teres minor muscle edema may be posttraumatic or neurogenic in origin, no space-occupying mass or fluid collection noted in the quadrilateral space."

The office visit by **XXXX** dated **XXXX** indicates the claimant complained of mild to moderate left shoulder pain rated as 5/10. The pain was aggravated by any movement, work duties, overhead activity, and lifting and relieved by rest and medication. It was noted that the claimant did not get relief from **XXXX** injection performed **XXXX**. Current medications included Mobic, Tramadol, and Ibuprofen. Examination of the left shoulder revealed normal sensation and normal deep tendon reflexes. There was decreased strength of the supraspinatus 3/5 and infraspinatus 4/5. There was popping on movement and anterior instability. There was positive Neer's impingement test, Hakwins Kennedy impingement test,



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Neer AC differentiation test, acromioclavicular crossover adduction test, biceps load test, infraspinatus test, Jobe's test, O'Brien's test, SLAP apprehension test, Speed's test, supraspinatus test, and Yergason's test. There was negative abdominal compression test, anterior slide test, drop-arm test, empty can test, Hornblowers sign, lift-off sign, and teres minor test. It was noted that the claimant continued to have activity limiting shoulder pain which has not improved with conservative treatment including medications, physical therapy, and a cortisone injection. The diagnosis was left high grade partial tear rotator cuff tear, posterior labral tear, perilabral cyst, SLAP tear, biceps tendinopathy, type 2 acromion, and AC joint arthritis. **XXXX** recommended left shoulder arthroscopy with acromioplasty, distal clavicle excision, extensive debridement, capsular release, tenolysis, loose body removal, rotator cuff repair, labral repair, slap repair, biceps tenodesis.

Prior UR letter dated **XXXX** denied the request for coverage of Left Shoulder Arthroscopy with Acromioplasty, Distal Clavicle Excision, Extensive Debridement, Capsular Release, Tenolysis, Loose Body Removal, Rotator Cuff Repair, Labral Repair, SLAP Repair, Biceps Tenodesis; 29827, 29828, 29807, 29826, 29824, 29823, and 29813 stating “per evidence-based guidelines, surgery is indicated in patients with concordant subjective and objective findings after the provision of 3-6 months of conservative care. In this case, the patient does have MRI evidence of a SLAP tear, biceps tendinopathy, and a partial thickness cuff tear. **XXXX** symptoms and exam findings are consistent with this diagnosis. **XXXX** has been treated with approximately 7 weeks of conservative care including rest, activity modification, NSAIDs, and PT. However, the guidelines recommend 3-6 months of conservative care prior to consideration of surgical intervention. Therefore, the request is not supported as there is incomplete conservative care based on the guidelines at this time. The request is not supported.”

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

The claimant is a **XXXX** who sustained injury to the left shoulder on **XXXX** and was diagnosed with left high grade partial rotator cuff tear, posterior labral tear, perilabral cyst, SLAP tear, biceps tendinopathy, type 2 acromion, and AC joint arthritis. The request is for coverage of Left Shoulder Arthroscopy with Acromioplasty, Distal Clavicle Excision, Extensive Debridement, Capsular Release, Tenolysis, Loose Body Removal, Rotator Cuff Repair, Labral Repair, SLAP Repair, Biceps Tenodesis; 29827, 29828, 29807, 29826, 29824, 29823, and 29813.

According to the Official Disability Guidelines, the criteria for rotator cuff repair, surgery for biceps tenodesis and SLAP lesions, and debridement/acromioplasty require at least 3 to 6 months of conservative treatment. In this case, review of the medical records showed that the claimant has been treated with conservative treatment including rest, physical therapy, activity modification and NSAIDs for only 7 weeks at the time the request was made. The ODG recommends surgical intervention only after 3-6 months of failure to progress with conservative treatment. For this reason, the requested left shoulder surgical procedure is not medically necessary at this point due to incomplete trial of conservative care. If the claimant remains symptomatic after at least 3 months from the injury then the claimant is considered a surgical candidate since the claimant meets other ODG indications for surgery including subjective complaints, objective findings, and imaging findings.

Therefore, based on the Official Disability Guidelines as well as the clinical documentation stated above, it is the opinion of this reviewer that the request of coverage for Left Shoulder Arthroscopy with



Acromioplasty, Distal Clavicle Excision, Extensive Debridement, Capsular Release, Tenolysis, Loose Body Removal, Rotator Cuff Repair, Labral Repair, SLAP Repair, Biceps Tenodesis; 29827, 29828, 29807, 29826, 29824, 29823, and 29813 is not considered medically necessary and appropriate in this claimant at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

**Official Disability Guidelines (ODG) – Online Version
Shoulder (Acute & Chronic) - (updated 12/18/17)
Surgery for rotator cuff repair
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).

**Surgery for impingement syndrome
ODG Indications for Surgery™ -- Bursectomy/Debridement and/or Acromioplasty:**

Criteria for subacromial decompression for subacromial impingement syndrome (80% improve without surgery.) Not recommended as an isolated procedure.



1. Conservative Care: Recommend at least 1 year unless meets earlier surgical criteria for other associated shoulder diagnoses: Physical therapy combined with home exercise, NSAIDs, corticosteroid injection, and taping are beneficial. Treatment must be directed toward gaining full motion with stretching and strengthening to re-balance shoulder musculature. PLUS
2. Subjective Clinical Findings: Significant functional impairment persisting at least 1 year. AND Pain with active arc motion between 90-130 degrees. AND Pain at night. PLUS
3. Objective Clinical Findings: Tenderness over rotator cuff 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 view), AND MRI, ultrasound, or arthrogram shows positive evidence of impingement (subacromial bursitis, rotator cuff tendinosis, Type II or III acromion).

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 (NSAIDs, 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)

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 sublabral 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 (< 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.

ODG Indications for Surgery™ -- Partial claviclectomy:

Criteria for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint:

1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS
2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS
3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS
4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation.

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NOTICE ABOUT CERTAIN INFORMATION LAWS AND PRACTICES With few exceptions, you are entitled to be informed about the information that the Texas Department of Insurance (TDI) collects about you. Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However, TDI may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that TDI correct information that TDI has about you that is incorrect. For more information about the procedure and costs for obtaining information from TDI or about the procedure for correcting information kept by TDI, please contact the Agency Counsel Section of TDI's General Counsel Division at (512) 676-6551 or visit the Corrections Procedure section of TDI's website at www.tdi.texas.gov.