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IRO REVIEWER REPORT

May 8, 2018

IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Denial of Right Shoulder Arthroscopy with Limited Chondral Debridement/Possible Microfracture, Possible Superior Labral Repair vs Biceps Tenodesis, Subacromial Decompression

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

This case was reviewed by a Board-certified Orthopedic Surgeon who is considered to be an expert in their field of specialty with current hands on experience in the denied coverage

REVIEW OUTCOME:

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

X	Partially Overturned	Upheld	Right shoulder subacromial decompression
		Overtured	Right Shoulder Arthroscopy with Limited Chondral Debridement/Possible Microfracture, Possible Superior Labral Repair vs Biceps Tenodesis

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a XX who injured XX right shoulder on XXXX. The mechanism of injury is not documented. XX was treated conservatively with activity modifications, home exercises, a course of formal physical therapy, medications, and steroid injections (per XX note dated XXXX, specific injection unclear). XX continued to report range of motion deficits and pain, and XX had continued difficulty performing XX job as a result.

XXXX: Initial note from XX. Physical therapy was initiated in XXXX. Patient had minimal improvement, limited mobility, and continued pain. Exam revealed 170 degrees forward flexion and abduction with pain, 4+/5 biceps strength and pain with resistance, positive Hawkins, negative O'Briens and Neers.

XXXX (XX): Patient still symptomatic after XX of PT. Conservative treatments included activity modification, home exercises, physical therapy, steroid injections (unclear specific site), oral medications. XX was referred for MRI shoulder.

XXXX: MRI of the right shoulder revealed rotator cuff intact, tear of superior labrum, and focal full-thickness cartilage defect at the anterior glenoid near the condrolabral junction with 3mm chondral flap.

PT notes reviewed from XXXX and XXXX: Patient completed formal PT program and modalities. XX continued to experience pain and overhead ROM deficits.

XXXX (XX): XX returned for MRI review. No improvement with conservative treatments. XX was doing formal PT and home exercises. Exam unchanged from XXXX. Treatment options were discussed including surgery to include shoulder arthroscopy, labral repair vs biceps tenodesis, chondral debridement versus microfracture.

XXXX: (XX): XX returned for followup. XX reported no relief in pain with continued ROM deficits. Exam revealed mild-moderate tenderness to palpation over biceps and greater tuberosity. XX had decreased forward flexion and abduction to 160 degrees, internal rotation with pain to T10, 4+/5 biceps strength with mild pain with resistance. Positive Hawkins/Neers/O'Briens tests. Surgery was again discussed and recommended.

This case underwent 2 previous adverse determinations:

- 1) XX (XXXX): Request denied secondary to limited subjective and objective findings to fully meet criteria for surgery.
- 2) XX (XXXX): Request denied as conservative care had not been attempted for > XX.

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

Review of records revealed that the patient has undergone a course of conservative treatment for XX to include activity modifications, home exercise program, formal physical therapy, medications, and injections. XX has history, physical exam findings (positive O'Briens test on XXXX), and imaging findings dated XXXX consistent with SLAP tear and focal full-thickness cartilage defect with 3 mm chondral flap. XX had interval worsening in XX physical exam findings despite an adequate course of conservative care. Given XX age (>XX), the SLAP tear would likely be treated optimally with biceps tenodesis. XX meets ODG criteria for surgery to address SLAP lesions and biceps tenodesis as outlined below. The request for debridement vs microfracture of the chondral flap as secondary procedures is also considered medically necessary with the procedure to address the SLAP/biceps complex as the primary procedure. As such, the criterion of 1 year requirement for conservative care is not required as these procedures are not isolated procedures. XX fully meets the ODG requirements for shoulder debridement as well. Regarding the subacromial decompression, XX does not completely meet subjective and imaging requirements (pain at 90-130 through arc of motion, pain at night, subacromial injection, and imaging findings consistent with impingement). Previous adverse determinations were made secondary to lack of subjective/objective findings to fully meet criteria and lack of conservative care over XX, however these deficiencies were clarified and/or met in the most recent clinical note. As such, it is the professional opinion of this reviewer that the request is partially overturned. The treatment criteria for biceps tenodesis and chondral debridement vs microfracture have been adequately established while treatment criteria for subacromial decompression have not as per the ODG treatment recommendation.

In other words, the request for coverage of Right Shoulder Arthroscopy with Limited Chondral Debridement/Possible Microfracture, Possible Superior Labral Repair vs Biceps Tenodesis is medically necessary

and appropriate. However, the request for coverage of subacromial decompression is not medically necessary and appropriate.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES - ONLINE VERSION

Shoulder (Acute & Chronic) - (updated 12/18/17)

Arthroscopic debridement (for shoulder arthritis)

ODG Indications for Surgery -- Shoulder Arthroscopic Debridement for Arthritis:

Glenohumeral joint osteoarthritis, post-traumatic arthritis, or rheumatoid arthritis with all of the following:

- (1) More likely benefit under age 60 (contraindicated over 60 with humeral head deformity, large osteophytes and/or significant motion loss unless mechanical locking due to loose body);
- (2) Moderate to severe pain (preventing a good night's sleep) or functional disability that interferes with activities of daily living or work;
- (3) Positive imaging findings of shoulder joint degeneration with small lesions, preferably involving only one side of joint;
- (4) Conservative therapies (including NSAIDs, intra-articular steroid injections, and physical therapy) have been tried and failed for at least 6 months;
- (5) If rheumatoid arthritis, tried and failed anti-cytokine agents or disease modifying anti-rheumatic drugs.

Surgery for SLAP lesions

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.

Surgery for biceps tenodesis (or tenotomy)**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)

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).

The ODG Shoulder Chapter does not address the request for Microfracture. Therefore, alternative ODG Knee and Leg Chapter is referenced.

Knee and Leg (Acute and Chronic) - (updated 05/04/18)**Microfracture surgery (subchondral drilling)****ODG Indications for Surgery™ -- Microfracture surgery**

Procedure: Subchondral drilling or microfracture. Requires all 4 below:

1. Conservative care: medication OR physical therapy (minimum of 2 months); PLUS
2. Subjective clinical findings: joint pain AND swelling; PLUS
3. Objective clinical findings: full thickness chondral defect on the weight bearing portion of the medial or lateral femoral condyle on MRI or during arthroscopy AND the knee is stable with intact, fully functional menisci and ligaments AND normal knee alignment AND normal joint space; PLUS
4. Age 45 or younger.