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DATE: 4/11/18
IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left Shoulder Arthroscopy with Acromioplasty, Distal Clavicle Excision, Extensive Debridement, Loose Body Removal, Labral Repair, Capsulorrhaphy, Excision of Perilabral Cyst, Biceps Tenodesis, Possible Rotator Cuff Repair

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is certified by The American Board of Orthopedic Medicine with a primary practice in Orthopedic Surgery and a secondary practice of Pediatric Orthopedics; this physician has over 18 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Partially Overturned (Agree in part/Disagree in part

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
XX with left shoulder pain after an injury that occurred at work on XXXX. Patient reports XX was trying to XX on XX left side; injuring XX shoulder.

XXXX: MRI Left Shoulder. Impression-Complex tearing involving the posterior inferior aspect of the labrum with degenerative intrasubstance signal also noted throughout the posterior labrum. A 12mm lobulated paralabral cyst extrudes inferiorly.

XXXX: Office Visit with XX. Acute onset shoulder pain occurring for XX. Course has been constant. Pain is moderate. Characterized by sharp and stabbing in the left shoulder. The pain has been aggravated by physical activity and work duties. Relieving factors include rest and modification of activity. Associated features include: muscle swelling and weakness, painful ROM, difficulty with overhead activities, difficulty with pushing, pulling and lifting. Trouble sleeping at night due to the pain. XX also reports some tingling that radiates down the arm into the fingers. No previous Physical Therapy. No previous surgeries. No use of assistive devices. No previous medication therapy. Examination of Left Shoulder reveals: normal sensation, normal deep tendon reflexes and coordination and neurovascularity intact. Strength and Tone- Left – Deltoid: 5/5. Pectoralis Major-5/5. Supraspinatus- 3/5. Infraspinatus- 4/5. Subscapularis- 5/5. Biceps- 5/5. Instability-Left Shoulder: **Positive** circumduction test, jerk test, Jobe relocation test, loads and shift test, popping on movement of shoulder, posterior apprehension test, drawer chest and posterior instability test. Negative anterior drawer test, apprehension test, multi-directional instability and sulcus sign. Shoulder- Impingement- Hawkins' Kennedy test positive on left, impingement test positive and Neer AC and Neer impingement test positive. Functional Testing-Left- Positive AC crossover adduction test, biceps load test, infraspinatus, Jobe test, Obrien's test, SLAP prehension test, Speed's test, Supraspinatus t3est and Yergason's test. Left Negative- abdominal compression test, anterior slide test, drop-arm test, empty can test, Hornblower's sign, lift off sign and teres minor test. Assessment- Glenoid Labrum Tear, Left. Left posterior labral tear from 2 o'clock to6 o'clock with peri-labral

cyst at 6 o'clock, low grade partial tear RTC, biceps tendonitis, type 2 acromion, AC joint arthritis; s/p Left open RTC repair another surgeon. PT Eval, Arthrocentesis major joint or bursa with US guidance. XX 40MG injection, bupivacaine injection, US, X-ray of shoulder. Start XX 15MG QD. Plan is to treat patient conservatively with a combination of medicine, exercise and a cortisone injection. Pt given Rx for anti-inflammatory drug. PT prescription. Follow-up in XX to see how XX doing. If the pain continues, the pt may benefit from arthroscopic surgery.

XXXX: Office Visit with XX. Pt continues to have activity limited pain and instability which has not improved with conservative treatment including medications and physical therapy. At this point, I feel the patient will likely not improve without surgical intervention. Plan will be Left Shoulder Arthroscopy with Acromioplasty, Distal Clavicle Excision, Extensive Debridement, Loose Body Removal, Labral Repair, Capsulorrhaphy, Excision of Perilabral Cyst, Biceps Tenodesis, Possible Rotator Cuff Repair.

XXXX: IRO Review. Denied based on the fact there has been no documentation in the record of physical therapy. I also feel the rotator cuff repair, subacromial decompression, biceps tenodesis, and distal clavicle resection are not medically necessary based on review of the records. I do feel that if a patient has completed 3-6 month course of PT and continues to have pain and instability, that the arthroscopic repair of the posterior labral tear and possible posterior capsular plication would be reasonable and necessary.

XXXX: Physical Therapy Re-Evaluation. Pt reports back to PT after a XX break. XX reports XX shoulder pain is worse. Pain and stiffness in the GHJ that has not improved. Fair prognosis. Pt had previously improved with PT. On XX last Re-eval, XXXX, I recommended cont PT or other intervention. XX was not referred back to PT and in XX has digressed in pain, ROM and strength. Recommend PT for XX and or other intervention to improve function, lifting and ROM. Short Term Goals- Pt will be indep with HEP-MET. Improve pain 1-2 grades. Restore ROM. Long Term Goals- Improve pain WFL. Improve AROM to WNL. Improve strength in left shoulder by 1-3 grade. Gradually transition back to work duties. Improve functional score by 15-20%.

XXXX: Physical Therapy Re-Evaluation. Patient cont to have pain and some weakness which limits lifting and overhead reach capacity. This is consistent with XX prior symptoms and limitations. XX reports a higher SPADI score than prior, which indicates greater perceived shoulder disability. It is likely that unless there is some other level of intervention, further PT will not significantly change XX status. Short Term Goals- Pt will be indep with HEP-MET. Improve pain 1-2 grades-MET. Restore ROM-PROGRESSING. Long Term Goals- Improve pain WFL-PROGRESSING. Improve AROM to WNL PROGRESSING. Improve strength in left shoulder by 1-3 grade-MET. Gradually transition back to work duties PROGRESSING. Improve functional score by 15-20%-NOT ATTAINED.

XXXX: Office Visit with XX. Pt here for follow up on left shoulder. XX is still having constant pain, has radiating burning with pain from XX left side of XX neck to XX left shoulder. Previous physical therapy has included: active assisted ROM exercises and active ROM exercises. XX already completed physical therapy. Pt continues to have activity limited pain and instability which has not improved with conservative treatment including medications and physical therapy. At this point, I feel the patient will likely not improve without surgical intervention.

XXXX: Office Visit with XX. Pt is still having constant pain. Now the pain I radiating up XX neck and XX is now having headaches.

XXXX: UR by XX. Rationale- based on clinical information submitted for this review and using evidence based, peer-reviewed guidelines, this request is non-certified. There was insufficient significant objective findings and functional limitations that would fully support the need for the requested surgeries of the left shoulder. Also, the provision of conservative treatments that were tried and had failed was not established in the medicals provided before considering surgery as there were no physical therapy notes and procedure reports submitted.

XXXX: Pt is here for discussion of surgery denial for left shoulder. XX still having a lot of pain in shoulder, has no improvement at this time. Meds: XX 15MG QD, XX 25MG PRN, XX 50MG Q6HRS PRN, XX 10MG, XX.

XXXX: UR by XX. Rationale- Several of the codes or procedures are NOT supported. Specifically rotator cuff repair, SLAP repair and loose body removal are not supported as there is no imaging evidence of rotator cuff tear, SLAP tear, or loose body. Thus the entirety of the request is not supported.

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

The previous adverse decisions are Partially Overturned. This patient injured XX shoulder in XXXX. XX left shoulder MRI confirmed a tear of the posterior labrum and a paralabral cyst. The MRI also identified a prior acromioclavicular (AC) joint resection. The patient has failed a medication, XX injection and physical therapy. In XXXX, the physical therapist felt that additional physical therapy would not improve the patient's condition. The treating physician has recommended left shoulder arthroscopy with acromioplasty, distal clavicle excision, extensive debridement, loose body removal, labral repair, capsulorrhaphy, excision of paralabral cyst, biceps tenodesis, and possible rotator cuff repair. The patient has received conservative care for over a year. XX continues to have shoulder pain while taking NSAIDs and pain medication.

The decision to move forward with additional procedures (rotator cuff) is based on the pathology identified at the time of surgery. Additional findings are frequently encountered with a diagnostic arthroscopy, especially when the MRI was performed one year ago. Specifically:

1. If a loose body is found, it should be removed.
2. If a rotator cuff tear is identified, the rotator cuff repair should be repaired.
3. Biceps tenodesis can be considered based on the condition of the biceps tendon at the time of surgery.

XX is a surgical candidate at this point in time. XX underlying pathology is a posterior labral tear. It would be appropriate for XX to undergo a left shoulder arthroscopy with extensive debridement of the labrum, possible labral repair, capsulorrhaphy, and excision of paralabral cyst. An acromioplasty is recommended in this patient with shoulder impingement and decreased shoulder motion and strength, especially in the setting of a prior rotator cuff repair (XXXX). Therefore, the request for **left shoulder arthroscopy with acromioplasty, extensive debridement, loose body removal, labral repair, capsulorrhaphy, excision of paralabral cyst, biceps tenodesis, and possible rotator cuff repair are considered Medically Necessary**. The requested **distal clavicle excision is NOT Medically Necessary**, without MRI evidence of arthritis in the AC joint. XX office notes reported AC joint arthritis on xray, which contradicts the MRI report. Further clarification is required for this procedure.
PER ODG…..XX

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

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**