MEDRx

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Notice of Independent Review Decision

DATE OF REVIEW: January 4, 2018

IRO CASE #: XXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Medical necessity of: right shoulder arthroscopy, decompression, distal clavicle excision and rotator cuff repair (29827,29826, 29824).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in orthopedic surgery.

REVIEW OUTCOME

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

☒Upheld (Agree)

☐Overturned (Disagree)

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

The reviewer agrees with the previous adverse determination regarding the medical necessity of right shoulder arthroscopy, decompression, distal clavicle excision and rotator cuff repair (29827, 29826, 29824).

PATIENT CLINICAL HISTORY [SUMMARY]:
This patient is a XXXXX XXXX who sustained an industrial injury on XXXX. Injury occurred when XXXX and heard a snap in XXXX right shoulder with gradual worsening pain over the remainder of XXXX work shift. The XXXX right shoulder x-ray report documented mild degenerative changes of the acromioclavicular (AC) joint. The XXX treating physician report cited persistent right shoulder pain with limited range of motion. Right shoulder exam documented restricted and painful range of motion with mild tenderness. The diagnosis was right shoulder sprain and AC joint arthropathy. The treatment plan recommended a right shoulder MRI, continued light duty, and continued NSAIDs. The XXXX right shoulder MRI impression documented moderate supraspinatus tendinopathy with a full thickness tear in the distal anterior tendon near the insertion and fluid area in the adjacent subdeltoid bursa space.

There was moderate infraspinatus and subscapularis tendinopathy present, and findings suggestive of a partial tear of the distal subscapularis near the insertion. There was mild glenohumeral joint osteoarthritis with a moderate-sized effusion, and degenerative signal was noted within the anterior labrum. There was moderate bicipital tendinopathy with no tendon tear. The AC joint demonstrated a type I acromion with moderate degenerative callus formation. The XXXX orthopedic report cited worsening right shoulder pain. XXXX could not sleep at night and tramadol was not controlling XXXX pain. Pain was rated grade 4/10. XXXX reported some numbness going down into XXXX arm which was unrelated to XXXX shoulder. Right shoulder exam documented forward flexion 140, abduction 140, and internal and external rotation 45 degrees. Hawkins, Neer's, and empty can signs were positive. As the surgical request is not supported, this request is not medically necessary. The diagnosis was rotator cuff tear. The treatment plan recommended physical therapy and a corticosteroid injection was performed to the right shoulder. A review of the physical therapy records indicated that the patient was initially evaluated on XXX and attended one additional visit on XXX. The XXXX orthopedic report cited persistent right shoulder pain, including pain at night and with overhead activities. XXXX had been sent to physical therapy and had an injection which did not help XXXX much. Current medications included tramadol. Right shoulder exam documented range of motion as forward flexion 140, abduction 140, and internal and external rotation 45 degrees. Hawkins, Neer's, and empty can signs were positive. The diagnosis was rotator cuff tear. At this point, XXXX had failed conservative management. The treatment plan recommended a rotator cuff repair. The XXXX peer review determination indicated that the request for right shoulder arthroscopy, decompression, distal clavicle excision, and rotator cuff repair was non-certified. The rationale stated that there was limited documentation of significant functional limitation and alteration in activities of daily living, and clarification was needed if XXXX had already exhausted conservative treatments prior to a surgical intervention. The XXX peer review reconsideration determination non-certified the request for right shoulder arthroscopy, decompression, distal clavicle excision, and rotator cuff repair. The rationale stated that there were limited physical therapy reports submitted and no recent evaluation to validate exhaustion and failure of rehabilitative efforts as guidelines recommend 3-6 months of conservative care prior to considering surgery. The rationale also stated that there were no additional medical records submitted noting significant objective changes to overturn the previous denial of this request.

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

The request for right shoulder arthroscopy, decompression, distal clavicle excision, and rotator cuff repair (CPT codes 29827, 29826, 29824) is not medically necessary. The denial of this request is upheld. The Official Disability Guidelines provide specific indications for rotator cuff repair of small full thickness or partial thickness rotator cuff tear or acromial impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Guidelines state that 3 months is generally adequate if treatment has been continuous, 6 months if intermittent. Earlier surgical intervention may be required with failure to progress with therapy, high pain levels, and/or mechanical catching. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff, greater tuberosity, or anterior acromial area, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of rotator cuff deficiency. Guideline criteria for partial claviculectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, aggravation of pain with shoulder motion or carrying weight, or previous Grade I or II AC separation, tenderness over the AC joint and or pain relief with diagnostic injection, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation.

This patient presents with persistent right shoulder pain with functional difficulty in overhead activities and pain at night. Clinical exam findings have documented painful and restricted range of motion and positive impingement and rotator cuff signs. There is imaging evidence of a full thickness supraspinatus tendon tear, partial thickness subscapularis tear, and AC joint arthropathy. Conservative treatment was documented for 2 months at the time of the surgical request to include activity modification, NSAIDs, opioid analgesics, 2 visits of physical therapy, and a corticosteroid injection without much improvement. Guideline criteria have not been fully met to support current surgical intervention for this patient. There is no documentation of at least 3 months of continuous or 6 months of intermittent conservative treatment, and failure. There is no documentation of a positive diagnostic impingement injection test. There is no documentation of rotator cuff weakness. There is no documentation of high pain levels or mechanical catching to support an exception to guidelines relative to conservative treatment. Therefore, the request for right shoulder arthroscopy, decompression, distal clavicle excision, and rotator cuff repair is not medically necessary.

References

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**
ODG-TWC
ODG Treatment
Integrated Treatment/Disability Duration Guidelines
Shoulder (Acute & Chronic)
Updated 12/18/17
Surgery for rotator cuff repair
Partial claviculectomy

☐ **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)**