MEDR X

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DATE OF REVIEW: July 22, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Right shoulder arthroscopic rotator cuff repair; right shoulder subacromial decompression; right biceps tenotomy; right shoulder labral debridement; right shoulder distal clavicle excision, left iliac crest bone harvest in transplantation of stem cells

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 arthroscopic rotator cuff repair; right shoulder subacromial decompression; right biceps tenotomy; right shoulder labral debridement; right shoulder distal clavicle excision, left iliac crest bone harvest in transplantation of stem cells

A copy of the ODG was not provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant is a XXXX who sustained an XX injury on XX. Injury occurred when XX was XX XX in an XX. XX stepped on a XX and fell XX XX, landing on XX heels and hit XX back, neck, and right side. Past medical history was positive for type 1 diabetes. Social history is positive for current same day smoker. A review of records documented conservative treatment to include XX, muscle relaxant, pain medication, activity modification, physical therapy, home exercise, and XX injection. The XX right shoulder MRI impression documented mild tendinosis at the junction of the distal supraspinatus and infraspinatus tendons. There was a 4 mm degenerative/insertional cyst and subtle marrow edema in the posterior lateral humeral head subjacent to the distal supraspinatus and infraspinatus tendons. Findings documented a type II acromion. The labrum and biceps tendon were reported intact. The XX orthopedic progress report indicated that the claimant was doing really well following physical therapy and injections until last week. XX reported that on XX, XX was on a couch and picked up XX XX baby. XX felt a sharp right shoulder pain that felt exactly the same as the first day XX injured it. XX saw XX primary treating physician and was prescribed XX and placed on work restrictions, but was not working due to the restrictions. Right shoulder exam documented decreased active range of motion with flexion 150, abduction 150, external rotation 30, and internal rotation 30 degrees, all limited by pain. Passive range of motion appeared normal but XX did have significant impingement to Neer and Hawkin's tests. There was tenderness over the long-head of the biceps tendon, and positive O'Brien's and Yergason's tests. The diagnosis included right shoulder impingement, partial thickness rotator cuff tear. XX had been getting better with conservative treatment but had a setback. The treatment plan recommended another XX injection. The XX orthopedic progress report cited complaints of persistent grade 7/10 right shoulder pain. XX had difficulty with overhead activity, weakness, and pain at night. XX could not go back to work regular duty. Cervical spine exam documented some mild pain with flexion, extension, and rotation, and pain that seemed to radiate into the posterior rhomboid area. XX had a positive Spurling's test. Right shoulder exam documented discrete tenderness with some palpable spurring over the distal clavicle and AC joint, positive cross arm test, positive Neer and Hawkin's impingement test, weakness and pain with resisted external rotation and flexion, positive Yergason's test, and tenderness over the long head of the biceps tendon. XX had normal passive range of motion. Active range of motion was documented as flexion 116 degrees and abduction 150 degrees, limited by pain. MRI was reviewed and showed type II acromion, subacromial impingement syndrome, AC osteoarthritis, high grade supraspinatus and infraspinatus tears with some cyst formation at the greater tuberosity, and findings suggestive of a biceps tendonitis. The labrum was somewhat poor visualized on the MRI. The claimant had failed conservative treatment including physical therapy, XXs, and two XX injection. XX had temporary relief from the XX injection which suggested that XX symptoms were correctable with surgery. The treatment plan recommended surgery including possible rotator cuff repair, subacromial decompression for acute impingement, possible biceps tenotomy versus tenodesis, and any superior labral debridement as needed. Pre-operative clearance was indicated because of XX XX-dependent diabetes. Work status was documented as modified work with restrictions outlined. The XX peer review determination report indicated that the total request for right shoulder arthroscopic rotator cuff repair, subacromial decompression, biceps tenotomy, labral debridement, distal clavicle excision, and left iliac crest bone harvest in transplantation of stem cells was non-certified. The rationale noted that the requests for right shoulder arthroscopic rotator cuff repair, subacromial decompression, and distal clavicle excision were medically necessary but remained non-certified as discussion with the treating physician to discuss treatment modification had not occurred. The request for biceps tenotomy was determined to be not medically necessary as MRI revealed only possible mild biceps tendinitis. The request for labral debridement was determined to be not medically necessary as there were no findings consistent with a labral tear. The request for left iliac crest bone harvest in transplantation of stem cells was determined to be not medically necessary as not recommended by the Official Disability Guidelines that noted further research was necessary. The XX peer review determination report indicated that the total request for right shoulder arthroscopic rotator cuff repair, subacromial decompression, biceps tenotomy, labral debridement, distal clavicle excision, and left iliac crest bone harvest in transplantation of stem cells was non-certified. The rationale noted that the requests for right shoulder arthroscopic rotator cuff repair, subacromial decompression, and distal clavicle excision were medically necessary but remained non-certified as discussion with the treating physician to discuss treatment modification had not occurred. The request for biceps tenotomy was determined to be not medically necessary. The rationale stated that the available information indicated a lack of evidence of biceps tendon pathology on imaging and the provider did not clearly indicate why this portion of the surgical intervention would be required. The request for labral debridement was determined to be not medically necessary. The rationale stated that the MRI did not reveal findings consistent with labral pathology. The request for left iliac crest bone harvest in transplantation of stem cells was determined to be not medically

necessary. The rationale stated that the Official Disability Guidelines did not support the use of stem cell transplantation in the shoulder, and the available clinical information did not indicate why this portion of the procedure would be required. The XX orthopedic progress report cited complaints of posterior, lateral and anterior right shoulder pain, grade 8/10. XX was limited in overhead movement and any use of XX arm. XX pain continued to wake XX up at night from sleep. Right shoulder exam documented normal passive range of motion and slightly decreased active range of motion in abduction, flexion, and external rotation. XX had 4-/5 weakness in resisted flexion and external rotation, positive Neer and Hawkin's impingement signs, long head biceps tenderness, positive Yergason's test, positive AC joint tenderness and some pain with cross arm abduction. MRI demonstrated a high-grade partial thickness tear and impingement syndrome. XX had some symptoms of an AC joint sprain injury with osteoarthritis of the AC joint. The diagnosis included right shoulder traumatic tear of the supraspinatus tendon, impingement syndrome, bicipital tendonitis, and arthritis of the AC joint. The claimant had continued pain, weakness and difficulty with overhead activity. XX had tried conservative treatment including 18 sessions of physical therapy, activity modification, and 2 XX injections with temporary relief. Surgical intervention had been requested and denied. The industrial causation relative to the right AC joint osteoarthritis was discussed. The treatment plan recommended right shoulder rotator cuff repair, subacromial decompression, and biceps tenodesis/tenotomy under the industrial claim. The XX orthopedic progress report indicated that surgery was requested for treatment of the right shoulder rotator cuff tear and acute impingement syndrome. XX also had AC arthritis that was symptomatic and likely pre-existing, which would support distal clavicle excision. It was noted that the biceps tendon would be evaluated at the time of surgery. There was some fluid around the biceps and XX had positive bicipital signs. If the biceps appeared inflamed, a biceps tenotomy would be recommended. XX had been medically cleared for surgery.

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

The prospective request for right shoulder arthroscopic rotator cuff repair; right shoulder subacromial decompression; right bicep tenotomy; right shoulder labral debridement; right shoulder distal clavicle excision; and left iliac crest bone harvest in transplantation of stem cells is not medically necessary. The denial is upheld. The Official Disability Guidelines (ODG) provide specific indications for rotator cuff repair of small full thickness or partial thickness rotator cuff tear or acromial impingement syndrome that include XX of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. 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.

Criteria for impingement surgery (subacromial decompression) generally include: At least XX of conservative treatment (physical therapy combined with home exercise, XX, XX injection and taping); Subjective clinical findings of significant functional impairment persisting for at least one year, pain with active arc motion from 90-130 degrees, and pain at night; Objective clinical findings of rotator cuff or anterior acromial area tenderness, positive impingement signs, and temporary relief of pain with diagnostic injection test; and, 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).

Biceps tenotomy is recommended for advanced biceps tendinopathy, subluxation/dislocation, or rupture under age XX (tenotomy/debridement XX) may be considered in patients XX XX with type II or IV SLAP lesions when other criteria are met and biceps specific symptoms are documented.

The ODG criteria for labral debridement state that generally, type I and type III lesions do not need any treatment, or can be lightly debrided if other arthroscopic shoulder procedures are indicated. Surgical criteria typically include 6 months of conservative treatment, and history, physical exam, and imaging indicating the high likelihood of SLAP tear. Guidelines state that definitive diagnosis of SLAP lesions is only by diagnostic arthroscopy.

Guideline criteria for partial claviculectomy generally require XX 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.

Stem cell autologous transplantation is not recommended by the Official Disability Guidelines based on the lack of high quality evidence.

This claimant presents with persistent grade 8/10 right shoulder pain. Functional difficulty is noted in overhead work and use of the right arm, and precludes return to work full duty. XX reports nocturnal symptoms. Clinical exam findings are consistent with imaging evidence of partial thickness supraspinatus and infraspinatus tears and findings of impingement morphology. Detailed evidence of long-term reasonable and/or comprehensive non-operative treatment, including physical therapy, home exercise, XX, and XX injections, and failure has been submitted. Guideline criteria have been met relative to rotator cuff repair surgery, subacromial decompression for impingement syndrome, and distal clavicle excision for reported AC joint osteoarthritis. Guideline criteria have not been fully met to support surgery at the level of the biceps tendon or labrum. There are physical exam findings of biceps tendon tenderness and positive Yergason's test. However, there are no imaging findings indicating the high-likelihood of labral pathology or biceps tendon pathology to support surgical intervention. Finally, guidelines do not recommend stem cell autologous transplantation in the shoulder. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of stem cell use or labral/biceps surgery as an exception to guidelines. Therefore, overall this request is not medically necessary.

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 Treatment
Integrated Treatment/Disability Duration Guidelines
Shoulder (Acute & Chronic)
(Updated 7/18/18)
Surgery for rotator cuff repair
Surgery for impingement syndrome
Surgery for biceps tenodesis (or tenotomy)
Surgery for SLAP lesions
Partial claviculectomy (Mumford procedure)
Stem cell autologous transplantation

☐ **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)**