

CASEREVIEW

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IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Shoulder Arthroscopy with Rotator Cuff Repair

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

This physician is a Board Certified Orthopedic Surgeon with over 16 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

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]:

The patient is a XX who sustained an injury on XXXX. A XXXX MRI showed degenerative changes and a rotator cuff tear. On XXXX XX underwent an open rotator cuff repair followed by post-operative PT. In XXXX XX had a right shoulder XX injection because of continued pain.

On XXXX, the claimant presented to XX with continued pain on the lateral side of the right shoulder. The pain was aggravated by use of the right hand. It was described as moderate in intensity. XX took XX for pain. On physical exam the shoulder was diffusely tender. XX had only 100 degrees of flexion and abduction. Further attempted motion was prevented by pain. XX had good grip strength in the right hand. Recent x-ray of the right shoulder showed no abnormality. Assessment: Right shoulder subacromial bursitis. Plan: Last injection only helped XX for a month, so no plans for injection. Referral for physical therapy.

On XXXX, the claimant presented to XX for continued right shoulder pain. XX completed an additional XX of physical therapy without relief. XX has not been able to take any NSAID treatment because of XX stage 3 kidney disease. XX does take XX over-the-counter with only mild pain relief. XX reported not really finding anything to give XX much relief. XX has trouble lifting or carrying any items with the right upper extremity, and even has trouble with driving or sleep-in greater than 8 hrs. On exam XX had tenderness in the biceps tendon and acromion. ROM was limited. Muscle weakness noted. Cross Arm, Hawkin's test and Impingement all positive. Plan: MRI recommended and evaluation by XX for further treatment recommendations. XX 50 mg was prescribed.

On XXXX, MRI Right Shoulder, Impression: 1. Rotator cuff repair with no evidence of tear. 2. Possible labral tear. 3. Long head of the biceps tenosynovitis.

On XXXX, the claimant presented to XX for follow-up of right shoulder pain. On examination XX had tenderness in the biceps tendon (rotator cuff insertion). Active abduction: 90, Passive abduction: 110, Forward Flexion: 120, External rotation: 40. Muscle strength: Abduction: 5/5, Supraspinatus: 4/5, Subscapularis: 4/5, Biceps: 4/5. Apprehension test was negative, Hawkin's test was positive and Speed's test was positive. No significant atrophy. XX previous incision was well-healed. XX reported MRI showed full-thickness tears of the supraspinatus and infraspinatus tendons. There was also increased fluid around the biceps tendon. Assessment: Complete rotator cuff tear of the right shoulder. Plan: Right shoulder arthroscopic rotator cuff repair with possible biceps tenotomy.

On XXXX, XX performed a UR. Rationale for Denial: The need for a rotator cuff repair is not confirmed by these records. Further validation is needed. I spoke with XX. XX said XX disagreed with the radiology reading but there was no amended report from the radiologist. The ODG would not support the need for a rotator cuff repair without a full thick ness tear.

On XXXX, XX performed a UR. Rationale for Denial: The ODG supports arthroscopic rotator cuff repair if there is diagnostic evidence indicating the tear, and there are subjective and Objective findings consistent with the diagnosis. The injured worker did have some weakness on examination with 4/5 on supraspinatus and subscapularis; however, the MRI indicates that there was no evidence of the recurrent tear to the rotator cuff following the previous cuff repair. Given no evidence of a rotator cuff tear seen on the MRI, the recommended rotator cuff repair is considered not medically necessary. In older patients over the age of 55, the ODG supports biceps tenotomy surgery for individuals that have subjective and objective complaints consistent with the diagnosis and have confirmation with diagnostic imaging. The injured worker does have weakness noted with biceps testing and pain with range of motion. The MRI study indicated labral pathology and long head biceps tenosynovitis. The requested biceps tenotomy is considered medically necessary.

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

The request for right shoulder arthroscopy with rotator cuff repair is denied.

This patient underwent a right shoulder open rotator cuff repair in XXXX. According to the report of the XXXX shoulder MRI, the rotator cuff repair was intact, without evidence of tear. In XXXX, XX continued to have pain and weakness in the shoulder. According to the treating physician's review of the MRI, a rotator cuff tear was present. XX recommended shoulder arthroscopy with rotator cuff repair.

Based on the records reviewed, there is no definite evidence that this patient has a rotator cuff tear, which requires repair. There is disagreement between the radiologists and treating orthopedic surgeon in regards to the condition of the rotator cuff in the XXXX MRI. If the patient continues to be symptomatic, further imaging of the right shoulder may allow for identification of a subtle tear in the rotator cuff.

The requested surgery is not medically necessary.

PER ODG:

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).

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)

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)