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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX shoulder scope, rotator cuff repair, XX decompression

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

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

X 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 XXXX, when XXXX was XXXX.

On XXXX, performed an initial evaluation at XXXX. The patient reported XX shoulder pain since XXXX. XXXX had been to XXXX where x-rays were obtained. Treatment thus far consisted of pain medication and sling immobilization. XXXX reported severe pain in the shoulder and inability to actively use XXXX arm. The pain was sharp, aching and throbbing in nature. It was worse with lifting, reaching, lying on the affected side. VAS 5/10. XXXX also reported locking or catching, popping and stiffness or loss of motion. Prior treatments were brace and pain medications. On XX shoulder exam, the patient could actively elevate the shoulder to about 90 degrees, limited by pain. Passive elevation was 160 degrees with significant pain. There was good internal rotation strength. There was some weakness with testing of the external rotation and supraspinatus strength. There was significant pain with impingement maneuvers. The patient was nontender over the AC joint. X-rays of the XX shoulder showed no fractures or lesions. There were no degenerative changes of the XX joint. There was XX. XXXX diagnosed XX shoulder injury and ordered magnetic resonance imaging (MRI) study of the XX shoulder. The patient was advised to continue with over-the-counter (OTC) NSAIDs or XXXX as needed for pain.

On XXXX, the patient underwent an MRI of the XX shoulder at XXXX. The study showed possible tear of the XX XX, XX of the XX, XX, XX, partial-XX tearing in the XX tendon, no

full-thickness tear or XX, XX XX, XX without tearing, XX in the AC joint and XX with XX and XX fibrosis XX space. There was increased fluid in the XX-XX, compatible with XX.

On XXXX, XXXX reviewed the MRI study and diagnosed incomplete tear of the XX rotator cuff. XXXX administered XX XX injection. The patient was advised to begin PT. XXXX was placed on light duty restrictions.

On XXXX, the patient attended therapy at XXXX. XXXX had attended XX session from XXXX.

On XXXX performed a follow-up evaluation. The patient reported 50% relief that lasted for only XX days when it began to slowly diminish. XXXX continued to report pain in the shoulder, worse with lifting or elevation. The XX shoulder exam revealed tenderness over the greater XX. There was significant pain with impingement maneuvers. There was painful arc of motion but no signs of adhesive capsulitis. There was pain with resisted XX. The diagnosis was incomplete tear of the XX rotator cuff. Because of failure to improve with conservative measures including a XX injection and a course of PT, XXXX recommended shoulder arthroscopy with rotator cuff repair versus debridement.

Per Utilization Review dated XXXX, the request for XX shoulder scope with XX decompression and rotator cuff repair was denied on the basis of following rationale: "*The Official Disability Guidelines (ODG) support a rotator cuff repair in conjunction with acromioplasty for individuals with partial thickness tears and corresponding objective findings of a painful arc of motion and nighttime pain and impingement tests have had temporary relief with anesthetic. There should be corresponding findings on MRI and failure to improve with conservative treatment. Although this claimant does have complaints of shoulder pain, there are no specific complaints of nighttime pain to support proceeding with an XX procedure. Physical examination also does not show any rotator cuff weakness. Considering the absence of these subjective complaints and objective findings, this request for a XX shoulder arthroscopy for a XX decompression and rotator cuff repair is not medically necessary.*"

Per Reconsideration dated XXXX, the denial for XX shoulder scope with XX decompression and rotator cuff repair was upheld on the basis of following rationale: "*The appealed request is for a XX shoulder scope XX decompression and rotator cuff repair. The previous review denied the request, stating "although this claimant does have complaints of shoulder pain, there are no specific complaints of nighttime pain to support proceeding with an arthroscopic procedure. Physical examination also does not show any rotator cuff weakness." The Official Disability Guidelines (ODG) support surgery for shoulder impingement only after at least one year of conservative treatment, as most claimants improve without surgery. This conservative treatment should include physical therapy, home exercise, non-steroidal anti-inflammatory drugs (NSAIDs), corticosteroids injections, and taping. Additionally, the ODG recommends a rotator cuff repair if there are symptoms of nighttime pain and weakness with rotator cuff testing. This claimant's injury only occurred 3 months ago on* XXXX *and there are no findings of nighttime pain or weakness with rotator cuff testing in the medical record. Considering the state of the injury and the lack of conservative treatment, this appealed request for a XX shoulder scope XX decompression and rotator cuff repair is not medically necessary.*"

On XXXX, the patient attended therapy at XXXX. This was XXXX ninth visit. XXXX presented with impairments involving ROM, soft tissue mobility, strength, pain, joint mobility. The therapist stated the patient would benefit from skilled therapy to allow XXXX to meet set established functional goals and return to PLOF stated in the initial evaluation. The pain scale was 7-8/10 versus 8/10 on XXXX. The XX shoulder ROM was flexion 160 degrees versus 120 degrees on XXXX; abduction 120 degrees versus 60 degrees on XXXX; internal rotation was within functional limits versus 60 degrees on XXXX; external rotation was 60 degrees versus 40 degrees on XXXX. The XX shoulder strength was flexion 4- versus 3+ on XXXX; abduction 3+ versus 3+; scaption 3+ versus 3+, internal rotation was 4- versus 4- and external rotation was 4- versus 4- on XXXX. The XX test, XX/XX and XX were positive. The plan was continued therapy XX times a XX for XX weeks.

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

XX

The MOI, symptoms, clinical findings and MRI are consistent with a partial thickness rotator cuff tear and impingement syndrome.

The previous two preauthorization reviewers denied the requested surgery based on a lack of documentation of night pain. The records herewith do not mention night pain. The ODG criteria for surgical intervention after three months includes the documentation of night pain. Therefore, the previous two denials appear to have been formulated appropriately in accordance with ODG criteria. The lack of documentation of night pain is the only missing criterion for approval of the requested surgical intervention.

☐ Medically Necessary

X Not Medically Necessary

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES