Becket Systems

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Description of the service or services in dispute: Surgery for XX shoulder for torn labrum.

CPT 29807: Arthroscopy of shoulder, surgical with repair of XX lesion
CPT 29823: Arthroscopy of shoulder, surgical with extensive debridement

Description of the qualifications for each physician or other health care provider who reviewed the decision: Board Certified Orthopedic Surgeon

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

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

Patient Clinical History (Summary) XXXX who was diagnosed with superior glenoid labrum lesion of the XX shoulder, initial encounter (XXXX). XXXX.

XXXX for a follow-up of XXXX XX shoulder pain. It was noted that subsequent to the injury, XXXX experienced persistent XX shoulder pain and dysfunction. XXXX had a superior labral anterior XX (XX) tear of the shoulder, which had been progressively symptomatic for quite some time and had not responded to conservative care. XXXX was going to be scheduled for repair but was denied by XX' XX because of Official Disability Guidelines. XXXX had been continuing to work, although with quite a bit of discomfort. Examination revealed essentially full passive range of motion in the shoulder but actively XXXX was very resistant to flexion or abduction past approximately 90 degrees because of discomfort. Again, no significant subacromial crepitus was noted. XXXX had discomfort with biceps tendon stress.

On XXXX for the follow-up of the XX shoulder pain. The shoulder continued to be very symptomatic and XXXX continued to have significantly limited activities. XXXX had been able to continue at work. Examination showed that XXXX had maintained a good range of motion in the shoulder but had quite a bit of discomfort with any sort of biceps tendon resistance.

A CT arthrogram of the XX shoulder dated XXXX revealed no acute XX abnormality. There was no evidence of full-thickness rotator cuff tear. X-ray arthrogram of the XX shoulder dated

XXXX showed mild arthritic changes of the XX joint. The glenohumeral joint appeared appropriate.

Treatment to date included medications (limited relief), injections to the XX shoulder (without significant relief), physical therapy (which actually increased XXXX symptoms).

Per a utilization review determination letter dated XXXX, the request for arthroscopic repair versus debridement XX tear of the XX shoulder was non-certified. Understanding the date of injury was XXXX, noting the specific criterion identified in the Official Disability Guidelines, a minimum of six months of conservative care was to be completed prior to pursuing surgical intervention. The standard was not met. Furthermore, what conservative care had been completed including physical therapy, oral medications, oral steroids, or a shoulder injection was not clear. Also, there was insufficient documentation of the treatment rendered to support surgical intervention. Lastly, the board-certified radiologist failed to identify a specific XX lesion and noted mild degenerative changes. The exact nature of the lesion was not reported. Additionally, XXXX; therefore, while noting each of the criterion identified in the Official Disability Guidelines, there was insufficient information presented to support the request.

A letter dated XXXX indicated that the reconsideration request was denied. It was determined that XXXX reviewed the additional records and the recommendation remained not medically necessary. There were no new imaging findings of a XX II or IV tear noted to change the determination. Therefore, the request for an arthroscopic repair versus debridement of XX tear in the XX shoulder, as an outpatient, was not medically necessary.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The ODG recommends surgery for type II and IV superior labrum anterior XX (XX) lesions following a failure of six months of conservative treatment. The ODG recommends arthroscopic debridement for the treatment of glenohumeral osteoarthritis as an alternative to shoulder arthroplasty. The provided documentation reveals persistent XX shoulder pain nearly 4 months out from injury despite treatment with medications, an injection and physical therapy; however, there is no evidence of a XX tear or glenohumeral osteoarthritis on the provided imaging radiology reports. The CT arthrogram from XXXX reveals intact glenohumeral articular cartilage. The study also revealed attenuation of the XX labrum, but there is no report of a XX tear. Based on the provided documentation and ODG recommendation, the surgery for XX shoulder torn labrum is not medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

☐ ACOEM-America College of Occupational and Environmental Medicine
☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
☐ DWC-Division of XX XX
☐ Policies and Guidelines European Guidelines for Management of Chronic XX Pain
☐ Interqual Criteria

- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☐ ODG-Official Disability Guidelines and Treatment Guidelines

Shoulder Chapter

Surgery for XX lesions
Recommended for persistent symptoms following six months of conservative treatment for isolated Type II or for Type IV XX lesions involving more than 50% of the biceps tendon anchor.
See XX lesion diagnosis for a discussion of frequent misdiagnosis and over-treatment related to high incidence of normal variants (either anterior sublabral recess, or a XX complex), poor correlation of physical findings with pathology, and limitations of imaging studies. See also Biceps tenodesis.
Criteria for Surgery for XX lesions:
- After 6 months of conservative treatment (NSAIDs, injection and PT) with symptoms and/or activity limitations significant enough to justify surgery.
- History, physical examination and imaging (which can only accurately rule out) indicate high likelihood of XX tear (beware confusion with anterior sublabral recess or XX complex in up to 25% of the population); review by musculoskeletal radiologist can increase accuracy of diagnosis.
- Definitive diagnosis of XX lesions is only by diagnostic arthroscopy.
Direct Repair:
- Isolated Type II lesions (detachment of superior labrum).
- Isolated Type IV lesions (more than 50% of the tendon is involved, vertical tear, XX-XX tear of the superior labrum, which extends into biceps, intrasubstance tear).
- Age < XX (otherwise consider biceps tenodesis)
- Avoid direct repair for revision XX surgery and with associated large rotator cuff repair (biceps tenotomy preferred).
- Worse outcomes with direct repair can be anticipated for overhead throwers and injured XX.
- XX repair with simultaneous anterior/anterior-inferior, or XX/XX-inferior labral repair; with documentation of prior dislocation(s) or clear instability on exam and correlating imaging.
Biceps Tenodesis:
- Age over XX (younger optional if overhead throwing athlete)
- Option for revision XX surgery or in combination with rotator cuff repair in younger (< age 55) individuals and those avoiding mild cosmetic deformity.
Biceps Tenotomy:
- Preferred for revision XX surgery, and with associated large rotator cuff repair, and for older (55 or above) patients.
Debridement:
- Generally, type I and type III lesions do not need any treatment or can be lightly debrided if other arthroscopic shoulder procedures are indicated.

Arthroscopic debridement (for shoulder arthritis)

Recommended as an alternative to shoulder arthroplasty for limited indications below.
See also Arthroplasty (shoulder); Reverse shoulder arthroplasty. Note: In the Knee Chapter, Arthroscopic surgery for osteoarthritis is Not recommended because arthroscopic lavage and debridement in patients with osteoarthritis of the knee is no better than placebo surgery, and arthroscopic surgery provides no additional benefit compared to optimized physical and medical therapy.
ODG Indications for Surgery -- Shoulder Arthroscopic Debridement for Arthritis:
Glenohumeral joint osteoarthritis, post-traumatic arthritis, or rheumatoid arthritis with all of the following:
(1) More likely benefit under age XX (contraindicated over XX with humeral head deformity, large osteophytes and/or significant motion loss unless mechanical locking due to loose body);
(2) Moderate to severe pain (preventing a good night's sleep) or functional disability that interferes with activities of daily living or work;
(3) Positive imaging findings of shoulder joint degeneration with small lesions, preferably involving only one side of joint;
(4) Conservative therapies (including NSAIDs, intra-articular steroid injections, and physical therapy) have been tried and failed for at least 6 months;
(5) If rheumatoid arthritis, tried and failed XX or disease XX drugs.

- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the XX to appeal this IRO decision by requesting a Texas Department of Insurance, Division of XX' XX (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.