

REVIEWER'S REPORT

DATE OF REVIEW: 05/13/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Shoulder arthroscopy with acromioplasty and biceps tenodesis.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. Notice of Independent Review case assignment
2. Company request for IRO
3. Two adverse determinations
4. Requestor's records from the medical center
5. MRI report dated 03/14/07 showing complete rupture of the proximal head of the long head of the biceps tendon with retraction distally, mild grade 1 strain of the supraspinatus, and a distal calcicular cyst

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is male who injured his left shoulder while dropping off some boxes to be shipped. He felt a pop and had immediate pain and decreased range of motion. He was seen at the RT and an MRI scan was obtained. This revealed proximal biceps tendon rupture. He was referred to an orthopedic surgeon who immediately recommended arthroscopic acromioplasty and biceps tenodesis. No conservative treatment was prescribed. The injured employee was noted to have decreased range of motion, pain, and weakness.

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

Arthroscopic management of acute biceps tendon ruptures in a male is not indicated. Conservative treatment including physical therapy, anti-inflammatory medications, and steroid injections are the treatment of choice. Most patients without a preceding history of chronic impingement will not require surgical management for ruptures of the long head of the biceps. There is no documentation of conservative treatment in this patient's care, and surgery is absolutely not indicated.

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

(Check any of the following that were used in the course of your review.)

- 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.) American Academy of Orthopedic Surgery Shoulder Knowledge Update