

# P-IRO Inc.

An Independent Review Organization  
835 E. Lamar Blvd., #394  
Arlington, TX 76011  
Fax: 866-328-3894

Notice of Independent Review Decision

**DATE OF REVIEW:** December 12, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Right Shoulder arthroscopy-repair of labral defects with SLAP

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

MD 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)

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Guidelines

Adverse Determination Letters, 11/6/07, 10/29/07, 10/19/07

Designated Doctor Exam 7/13/07

Records from Dr. 1/22/07 to 10/4/07

Operative reports 1/16/07, 3/9/07

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured employee has continued shoulder pain after shoulder arthroscopy. The pain increased during rehab and work hardening. Mild labral fraying was noted during the initial arthroscopy and a post-op MRI demonstrates findings consistent with labral pathology and possible proximal biceps tendon involvement.

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

Although this patient may very well require repeat shoulder arthroscopy and indicated procedures, the Reviewer's medical assessment is that patient's the

pain has been adequately characterized. There are additional methods of conservative care that must first be explored before surgery. Therefore, surgery cannot be authorized at this time based solely on the MRI findings.

Surgery for SLAP lesions	<p>Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See <a href="#">SLAP lesion diagnosis</a>. The advent of shoulder arthroscopy, as well as our improved understanding of shoulder anatomy and biomechanics, has led to the identification of previously undiagnosed lesions involving the superior labrum and biceps tendon anchor. Although the history and physical examinations as well as improved imaging modalities (arthro-MRI, arthro-CT) are extremely important in understanding the pathology, the definitive diagnosis of superior labrum anterior to posterior (SLAP) lesions is accomplished through diagnostic arthroscopy. Treatment of these lesions is directed according to the type of SLAP lesion. Generally, type I and type III lesions did not need any treatment or are debrided, whereas type II and many type IV lesions are repaired. (<a href="#">Nam, 2003</a>) (<a href="#">Pujol, 2006</a>) (<a href="#">Wheeless, 2007</a>)</p>
SLAP lesion diagnosis	<p>Recommend criteria below, and the use of shoulder arthroscopy. When the glenoid labrum becomes injured or torn, it is described as a labral tear. These tears may be classified by the position of the tear in relation to the glenoid (which is often called the “shoulder socket”). A SLAP tear is a tear in the labrum that covers the top part of the shoulder socket from front to back (Superior Labral tear from Anterior to Posterior). A SLAP tear occurs at the point where the long head of biceps tendon attaches. This type of tear occurs most commonly during falls on an outstretched arm. SLAP lesions have proven difficult to diagnose clinically. This study concluded that SLAP-specific physical examination results cannot be used as the sole basis of a diagnosis of a SLAP lesion. (<a href="#">Jones, 2007</a>) Pathology of the SLAP lesion poses a significant challenge to the rehabilitation specialist due to the complex nature and wide variety of etiological factors associated with these lesions. (<a href="#">Wilk, 2005</a>) SLAP lesions are becoming a more recognized cause of shoulder pain and disability. The diagnosis of these lesions is difficult due to vague symptoms and a high degree of overlap with other shoulder disorders, and this requires a high index of suspicion. Advances in MR arthrography may lead to advances in preoperative diagnosis of labral tears, but definitive diagnosis, classification, and management is greatly facilitated with the use of the shoulder arthroscopy. (<a href="#">Maurer, 2003</a>) See also <a href="#">Surgery for SLAP lesions</a>.</p> <p>Criteria for Classification of SLAP lesions:</p> <ul style="list-style-type: none"> <li>- Type I: Fraying and degeneration of the superior labrum, normal biceps (no detachment); Most common type of SLAP tear (75% of SLAP tears); Often associated with rotator cuff tears; These may be treated with debridement.</li> <li>- Type II: Detachment of superior labrum and biceps insertion from the supra-glenoid tubercle; When traction is applied to the biceps, the labrum arches away from the glenoid; Typically the superior and middle glenohumeral ligaments are unstable; May resemble a normal variant (Buford complex); Three subtypes: based on detachment of labrum involved anterior aspect of labrum alone, the posterior aspect alone, or both aspects; Posterior labrum tears may be caused by impingement of the cuff against the labrum with the arm in the abducted and externally rotated position; Type-II lesions in patients older than 40 years of age are associated with a supraspinatus tear whereas in patients younger than 40 years are associated with participation in overhead sports and a Bankart lesion; Treatment involves anatomic arthroscopic repair.</li> <li>- Type III: Bucket handle type tear; Biceps anchor is intact.</li> <li>- Type IV: Vertical tear (bucket-handle tear) of the superior labrum, which extends into biceps (intrasubstance tear); May be treated with biceps tenodesis if more than 50% of the tendon is involved. (<a href="#">Wheeless, 2007</a>)</li> </ul>

**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
  - OKU SHOULDER
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)