

Prime 400 LLC

An Independent Review Organization
240 Commercial Street, Suite D
Nevada City, CA 95959
Phone: (530) 554-4970
Fax: (530) 687-9015
Email: manager@prime400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/05/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Shoulder Arthroscopic SLAP Repair and Biceps Tenodesis, 23430, 29807

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

M.D., Board Certified Orthopedic Surgeon

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 and Treatment Guidelines

Adverse Determination Letters, 8/19/09, 9/9/09

Peer Review Reports, 08/19/09 and 09/08/09

MRI Report: 01/14/09

Office Notes, Dr.: 01/27/09, 02/24/09, 03/24/09, 04/21/09, 05/28/09, 06/26/09, 08/11/09, 08/25/09 and 09/15/09

Letter, 02/17/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who fell and landed on his left shoulder on xx/xx/xx. He initially treated for left shoulder strain, left arm strain, left wrist strain and left leg strain. The claimant reported persistent left shoulder pain with weakness and inability to lift, push or pull.

Reference was made to treatment with one month of physical therapy. Left shoulder MRI performed on 01/14/09 showed superior labral tear anterior to posterior; partial infraspinatus tendon tear; biceps tenosynovitis; subcoracoid bursitis; acromioclavicular arthropathy; type I acromion; small effusion; and intact supraspinatus and subscapularis. Dr. saw the claimant for orthopedic evaluation on 01/27/09. Physical examination demonstrated flexion to 140 degrees, external rotation to 40 degrees, internal rotation to T8; weakness and pain in the supraspinatus and infraspinatus; and very positive Speed's. Recommendation was made for physical medicine and Celebrex. Notation was also made to use of Ketoprofen cream. The claimant continued to treat with no significant change in examination findings. Reference

was made to delays in participating in physical medicine due to authorizations. On 05/28/09 notation was made the claimant had attended three physical medicine sessions and continued use of medications. On 06/26/09 Dr. reported less than fifty percent pain relief and on 08/11/09 Dr. noted no improvement with eight months of conservative management. Recommendation was made for left shoulder arthroscopy with superior labral anterior posterior (SLAP) repair and biceps tenodesis.

On 09/15/09 Dr. continued to recommend surgery with notation the claimant was psychologically young for his chronological age; had a slight lesion, type II, with biceps tenosynovitis; had no improvement with conservative care; the SLAP lesion was type II with more than fifty percent of the tendon involved; and the acromioclavicular joint arthropathy was not the disabling problem. Recommendation continued for left shoulder arthroscopy with SLAP repair and biceps tenodesis.

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

The evidence-based literature suggests that surgical intervention for SLAP tears and/or biceps tendonitis should be reserved for individuals who have failed exhaustive conservative care, who have subjective complaints of pain that are consistent with objective findings on imaging and physical exam.

The records reflect that this gentleman has been through conservative care, has imaging studies which document a SLAP tear. He has been through conservative care according to the records in the form of physical therapy and activity modification. Records indicate there is little to offer this individual short of surgical intervention.

Of note, the evidence-based literature suggests that biceps tenodesis is reserved for younger individuals and should not be done as an isolated procedure. This individual would still qualify as a young individual, and it does not appear as though the treating physician is simply recommending biceps tenodesis as an isolated procedure.

Thus, based on the information provided, this individual would appear to support the diagnosis of symptomatic SLAP tear in association with impingement and biceps tendinitis for which surgical treatment would be considered reasonable in this circumstance. The request meets the ODG criteria. The reviewer finds that medical necessity exists for Left Shoulder Arthroscopic SLAP Repair and Biceps Tenodesis, 23430, 29807.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates;
Shoulder- Surgery for SLAP Lesions

Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved.

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.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates;
Shoulder- Surgery for Biceps Tendon Rupture

Criteria for tenodesis of long head of biceps (Consideration of tenodesis should include the following: Patient should be a young adult; not recommended as an independent stand alone procedure. There must be evidence of an incomplete tear.) with diagnosis of incomplete tear or fraying of the proximal biceps tendon (The diagnosis of fraying is usually identified at the time of acromioplasty or rotator cuff repair so may require retrospective review.)

1. Subjective: C/o more than "normal" amt. of pain that does not resolve with attempt to use arm. Pain and function fails to follow normal course of recovery.

2. Objective: Partial thickness tears do not have classical appearance of ruptured muscle.
PLUS

3. Imaging: Same as that required to rule out full thickness RCT: XR, AND Gadolinium MRI, US, or arthrogram shows evidence of deficit in rotator cuff.

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

ACOEM-AMERICA 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)