

Notice of Independent Review Decision

DATE OF REVIEW:

12/22/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder biceps tenodesis, distal clavicle resection and possible anterior Bankart repair and/or capsular shifts between 11/10 - 01/09/2010.

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

Board Certified Orthopaedic Surgeon

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: **Upheld**

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The requested procedure (right shoulder biceps tenodesis, distal clavicle resection and possible anterior Bankart repair and/or capsular shifts between 11/10 - 01/09/2010) is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 12/04/09 MCMC Referral
- 12/04/09 Notice To Utilization Review Agent Of Assignment, DWC
- 12/04/09 Notice To MCMC, LLC Of Case Assignment, DWC
- 12/03/09 Confirmation Of Receipt Of A Request For A Review, DWC
- 12/01/09 Request For A Review By An Independent Review Organization
- 11/20/09 office note, Orthopedic Institute
- 11/17/09 report from ESIS Utilization Review Unit
- 11/16/09 report from M.D.,
- 11/10/09, 10/28/09 Workman's Compensation Preauthorization Form, Orthopedic Institute
- 11/06/09 office note, Orthopedic Institute
- 11/02/09 report from ESIS Utilization Review Unit
- 11/02/09 report from D.O.,
- 10/21/09, 09/25/09 office notes, , M.D., Orthopedic Institute

- 10/15/09 MR arthrogram right shoulder,
- 10/15/09 right shoulder arthrogram,
- 10/12/09 Report of Medical Evaluation, D.O., DWC, with attached Review of Medical History & Physical Examination
- 09/25/09, 10/21/09, 11/20/09 office notes, , M.D., Orthopedic Institute
- 09/15/09, 09/03/09, 08/24/09, 08/10/09 Encounter Notes, , M.D., MedClinic
- 08/05/09 Daily Note & Charge Sheet
- 08/05/09, 09/03/09 Therapy Status Reports, Fit for Work
- 08/03/09, 07/20/09, 07/10/09, 07/03/09 Encounter Notes, M.D., MedClinic
- 07/30/09 MRI right shoulder, Imaging
- 07/25/09 Encounter Notes, Karst, M.D., MedClinic
- 07/24/09 Encounter Notes, M.D., MedClinic
- 07/02/09 to 07/18 Physical Therapy Exercise Sheets, Fit for Work
- 07/01/09 Patient Information sheet, Fit for Work
- 07/01/09 Physical Therapy Evaluation, Fit for Work
- 06/26/09 chart note, MedClinic
- 06/26/09 Physical Therapy Referral, M.D., MedClinic
- 06/26/09 Encounter Notes, M.D., MedClinic
- 06/20/09 Encounter Notes, M.D., MedClinic
- 06/20/09 Alcohol Testing Form, Transportation
- Undated referral form for MR arthrogram right shoulder,
- Note: Carrier did not supply ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a female who was reported to have sustained a work-related injury on xx/xx/xx. The described mechanism of injury was pulling a dolly full of product over a curb when she felt a pop in her shoulder. There is no medical available until xx/xx/xx. She was seen for the first time at Medclinic on xx/xx/xx by M.D. She has seen at least six different providers at this facility. The primary diagnosis was a shoulder strain. A MRI of the right shoulder on 07/30/2009 noted no full thickness rotator cuff tears but evidence of biceps tendinopathy. She reported on 09/15/2009 to Dr. aggravating the shoulder after lifting a case of cigarettes on 06/20/2009. Various providers noted initially full range of motion and normal shoulder strength. On 07/24/2009 Dr. noted she aggravated her shoulder while looking at guns. Dr. referred the injured individual to Dr. because she had failed to respond to medications, therapy and injection and had nothing else to offer. M.D. evaluated the injured individual for the first time on 09/25/2009. His working diagnosis was impingement syndrome. He reported that the injured individual had full range of motion. He recommended a surgical procedure if the carrier denied MRI arthrogram. D.O. performed a Designated Doctor Evaluation on 10/12/2009. The injured individual was for the first time noted to be morbidly obese at 5'5" and a weight of 254 lbs. Dr. opined she was not at maximum medical improvement (MMI), but there is little objective physical findings documented in her examination. MRI arthrogram was performed on 10/16/2009 and revealed no full thickness rotator cuff tear, no Hill-Sachs or Bankart lesion, and no unstable labral tear. The biceps tendon anchor was reported as normal. Dr. re-evaluated her on 10/21/2009. His examination documented pain at the acromioclavicular (A-C) joint and biceps groove. There was a positive apprehension sign and positive relocation test. His diagnoses included

secondary impingement. He reported that the MRI showed biceps fraying and acromioclavicular joint derangement. He recommended a right shoulder biceps tenodesis, distal clavicle resection and possible anterior Bankart repair and/or capsular shift. His next visit noted that he had already recommended surgery which had been denied by the carrier.

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

The injured individual is a female who was reported to have sustained a work-related injury of her right shoulder. There is no information regarding the physical findings or treatment that the injured individual underwent immediately following the injury. The first medical is four days after the incident. Dr. reported that the injured individual had undergone two steroid injections prior to him. It was reported that one injection was in the area of the bicipital groove and the second to the acromioclavicular joint. They did not provide any improvement according to Dr.. Physical therapy was done with evidence of initial improvement, but later felt not to have been of any benefit. It is unclear why the injured individual had not returned to work since there was no specific physical deficit which would have precluded it.

Official Disability Guidelines:

Surgery for ruptured biceps tendon (at the shoulder): Not recommended except as indicated below. Nonsurgical treatment is usually all that is needed for tears in the proximal biceps tendons (biceps tendon tear at the shoulder). Surgery may be an appropriate treatment option for tears in the distal biceps tendons (biceps tendon tear at the elbow) for patients who need normal arm strength. (Mazzocca, 2008) (Chillemi, 2007) Ruptures of the proximal (long head) of the biceps tendon are usually due to degenerative changes in the tendon. It can almost always be managed conservatively, since there is no accompanying functional disability. Surgery may be desired for cosmetic reasons, especially by young body builders, but is not necessary for function. (Rantanen, 1999)

Official Disability Guidelines Indications for Surgery -- Ruptured biceps tendon surgery:

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 Clinical Findings: Complaint of more than "normal" amount of pain that does not resolve with attempt to use arm. Pain and function fails to follow normal course of recovery. PLUS
2. Objective Clinical Findings: Partial thickness tears do not have classical appearance of ruptured muscle. PLUS
3. Imaging Clinical Findings: Same as that required to rule out full thickness rotator cuff tear: Conventional x-rays, AP and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

Criteria for tenodesis of long head of biceps with diagnosis of complete tear of the proximal biceps tendon: Surgery almost never considered in full thickness ruptures. Also required:

1. Subjective Clinical Findings: Pain, weakness, and deformity. PLUS
2. Objective Clinical Findings: Classical appearance of ruptured muscle.

Criteria for reinsertion of ruptured biceps tendon with diagnosis of distal rupture of the biceps tendon: All should be repaired within 2 to 3 weeks of injury or diagnosis. A diagnosis is made when the physician cannot palpate the insertion of the tendon at the patient's antecubital fossa. Surgery is not indicated if 3 or more months have elapsed.

(Washington, 2002)

Based on the documentation, the injured individual has an unclear diagnosis. Diagnosis has included both impingement and instability. There are no clear documented findings that the injured individual had recurrent dislocation or subluxation. There is no mention of the injured individual's overall constitutional laxity. MRI noted a normal biceps anchor.

Official Disability Guidelines: Surgery for shoulder dislocation: Recommended as indicated below. The available evidence supports primary surgery for young adults, usually male, engaged in highly demanding physical activities who have sustained their first acute traumatic shoulder dislocation (glenohumeral joint). There is no evidence available to determine whether non-surgical treatment should not remain the prime treatment option for other categories of patient (i.e., for patient categories at lower risk of activity-limiting recurrence). (Handoll-Cochrane, 2004) (Gibson, 2004) Multiple traumatic shoulder dislocations of the glenohumeral joint indicate the need for surgery if they limit functional ability and if muscle strengthening fails. Rates of instability recurrence after surgery have been reported as 12% after open repair for anterior instability and 23% after arthroscopic anterior repair. (Sperber, 2001) (Jorgensen, 1999) Shoulder instability is classified as either traumatic or atraumatic based on the mechanism of injury. Traditional treatment for both forms of instability involves a nonsurgical approach, consisting of immobilization, rehabilitation, and a delay in the return to vigorous activities. This treatment is often quite successful in preventing recurrent dislocations in the patient with atraumatic instability. However, those patients with traumatic instability often experience further dislocations or subluxations, with recurrence rates as high as 94% in patients younger than 20 years. Open surgical reconstructions for anterior instability have been reported to be 94-100% successful in preventing recurrence. Arthroscopic stabilization procedures are successful in preventing recurrence in 80-90% of patients and result in low morbidity. However, the most common form of initial treatment for traumatic anterior shoulder instability remains immobilization, supervised rehabilitation, and gradual return to full activity. (Burgess, 2003) This study concluded that arthroscopic repair with suture anchors is an effective surgical technique for the treatment of an isolated Bankart lesion. Open repair does not offer a significantly better 2-year result in terms of stability, and furthermore, can negatively affect the recovery of full range of motion of the shoulder. (Fabbriciani, 2004) Initial treatment of shoulder subluxation or dislocation is conservative in nature followed by range of motion and strengthening exercises. However, if instability persists either activity modification or surgery may be considered. Activity modifications may be appropriate for those patients who can identify a single motion that aggravates instability, such as overhead throwing motions. Surgical treatment may be considered in those who are unwilling to give up specific activities (i.e., related to sports) or when instability occurs frequently or during daily activities.

Official Disability Guidelines Indications for Surgery -- Shoulder dislocation surgery:
Criteria for capsulorrhaphy or Bankart procedure with diagnosis of recurrent glenohumeral dislocations:

1. Subjective Clinical Findings: History of multiple dislocations that inhibit activities of daily living. PLUS History of multiple dislocations
2. Objective Clinical Findings: At least one of the following: Positive apprehension findings. OR Injury to the humeral head. OR Documented dislocation under anesthesia. PLUS
3. Imaging Clinical Findings: Conventional x-rays, AP and true lateral or axillary view. Criteria for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint:
 1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS
 2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS
 3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS
 4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation. (Washington, 2002)

The injured individual was reported to have undergone steroid injection without success which is a poor prognostic indicator. There is no evidence of behavioral evaluation despite a protracted course.

Official Disability Guidelines: Surgery for impingement syndrome. Recommended as indicated below. Surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. Since this diagnosis is on a continuum with other rotator cuff conditions, including rotator cuff syndrome and rotator cuff tendonitis, see also Surgery for rotator cuff repair. (Prochazka, 2001) (Ejnisman-Cochrane, 2004) (Grant, 2004) Arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff. (Gartsman, 2004) This systematic review comparing arthroscopic versus open acromioplasty, using data from four Level I and one Level II randomized controlled trials, could not find appreciable differences between arthroscopic and open surgery, in all measures, including pain, UCLA shoulder scores, range of motion, strength, the time required to perform surgery, and return to work. (Barfield, 2007) Operative treatment, including isolated distal clavicle resection or subacromial decompression (with or without rotator cuff repair), may be considered in the treatment of patients whose condition does not improve after 6 months of conservative therapy or of patients younger than 60 years with debilitating symptoms that impair function. The results of conservative treatment vary, ongoing or worsening symptoms being reported by 30-40% patients at follow-up. Patients with more severe symptoms, longer duration of symptoms, and a hook-shaped acromion tend to have worse results than do other patients. (Hambly, 2007) A prospective randomised study compared the results of arthroscopic subacromial bursectomy alone with debridement of the subacromial bursa followed by acromioplasty in patients suffering from primary subacromial impingement without a rupture of the rotator cuff who had failed previous conservative treatment. At a mean follow-up of 2.5 years both bursectomy and acromioplasty gave good clinical results, and no statistically significant differences

were found between the two treatments. The authors concluded that primary subacromial impingement syndrome is largely an intrinsic degenerative condition rather than an extrinsic mechanical disorder. (Henkus, 2009)

Official Disability Guidelines Indications for Surgery -- Acromioplasty:

Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.)

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS
3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement. (Washington, 2002)

There is no evidence of an adequate trial of conservative treatment as outlined above. The diagnosis is not clear and the pain generator has not been defined. The request does not meet the criteria as outlined by the Official Disability Guidelines.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES