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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/01/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right shoulder arthroscopy, SAD, rotator cuff repair, biceps tendon v/s labral repair.

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

MRI right shoulder, 07/02/09

Office notes, Dr., 07/17/09, 02/01/10, 03/24/10, 04/21/10, 05/26/10, 06/16/10

PT note, 03/19/10, 04/29/10, 05/03/10

Peer review, Dr., 05/11/10

Peer review, Dr., 06/10/10

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter shoulder, rotator cuff repair, subacromial decompression and ruptured biceps tendon repair

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury of xx/xx/xx. The MR of the right shoulder from 07/02/09 revealed supraspinatus tendinosis, no rotator cuff tear, acromioclavicular arthropathy, subacromial subdeltoid bursitis and anterior glenoid labral tear. The body of report documented slight lateral acromial downsloping and type 3 acromion. Dr. evaluated the claimant on 07/17/09. Dr. stated that the MRI of the right shoulder revealed acromioclavicular atrophy, subacromial deltoid bursitis and anterior glenoid labral tear and supraspinatus tendinosis. Neer and Hawkins signs were positive. Strength was 5-/5. There was mild crepitans in the shoulder. Diagnosis was rotator cuff syndrome, lateral epicondylitis, sprain of neck. Dr. saw the claimant on 05/26/10. Strength was 4+/5 in the right shoulder. There was pain with shoulder motion. Dr. recommended surgery. On 06/16/10, Dr. stated that he had not treated the claimant with a corticosteroid injection due to efficacy of an injection for labral pathology. Dr. also stated that he had wanted to maintain the integrity of the rotator cuff. Impingement sign was positive. Strength was 4+/5 on the right. There was pain over the proximal bicipital groove. There was mild popping in the shoulder. Diagnosis was rotator cuff syndrome. Off work was recommended. The claimant has been treated with physical therapy, antiinflammatory medications, pain medications and restrictions.

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

It would certainly appear that a labral tear was documented in this case, as well as tendinosis, which could indicate some degree of mechanical impingement. Conservative treatments have been documented, including pain medications, nonsteroidal anti-inflammatories, injections, and physical therapy. It appears that one of the previous reviewers did not have access to the treatment records. It appears that another reviewer did not have access to the MRI study of July 2009.

This claimant would satisfy ODG criteria. There certainly has been extended conservative care rendered with ongoing documentation of impingement findings and painful popping. The labral pathology will be best diagnosed via arthroscopy and the decision whether or not to repair the biceps anchor versus débride damaged labrum will be an intraoperative decision.

All in all, I believe that the information provided satisfies the ODG guidelines for medical necessity of arthroscopic surgery with intraoperative decision making to be determined, obviously, at the time of diagnostic evaluation. The reviewer finds that medical necessity exists for right shoulder arthroscopy, SAD, rotator cuff repair, biceps tendon v/s labral repair.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, Shoulder

ODG 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 (Tenderness over the greater tuberosity is common in acute cases.) 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 deficit in rotator cuff

ODG 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)

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)