

US Resolutions Inc.

An Independent Review Organization
1115 Weeping Willow
Rockport, TX 78382
Phone: (512) 782-4560
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/21/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left shoulder arthroscopy, SAD, RTC repair arthrotomy debridement biceps 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

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter shoulder, rotator cuff repair

MRI left shoulder, 04/01/10

Office notes, Dr., 04/29/10, 05/13/10

PT note, 05/10/10 to 05/26/10

Peer review, Dr., 06/04/10

Peer review, Dr., 06/22/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male with complaints of left shoulder pain. The MRI of the left shoulder revealed a 2 millimeter bursal surface tear within the anterior aspect of the supraspinatus tendon. There was a small amount of fluid in the subacromial/subdeltoid bursa. There was edema seen in the deltoid muscle body. Edema was more pronounced within the anterior portion of the deltoid. There was edema in the short head of the biceps. Biceps tendon was intact. There was no joint effusion. Glenoid labrum had a normal appearance. On 04/29/10, Dr. performed a diagnostic and therapeutic injection which provided relief and improved range of motion. On 05/13/10, Dr. saw the claimant. The claimant reported the injection provided some relief. Examination revealed tender greater tuberosity, pain above 60 degrees of forward flexion and improvement when the claimant reached 140 degrees. There was give way pain with abduction and external rotation. Mild crepitation was noted. Diagnosis was rotator cuff syndrome. The claimant has been treated with physical therapy, Naprosyn and tramadol.

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

The requested Left shoulder arthroscopy, SAD, RTC repair arthrotomy, debridement, biceps repair is not medically necessary based on review of this medical record. The MRI documents a very small abnormality on the superior aspect of the supraspinatus tendon with some edema in the short head of the biceps. Medical records from Dr. on 04/29/10 and 05/13/10 document the claimant's complaints, findings, and treatment.

On his second visit on 05/13/10 after two physical therapy and one subacromial injection they discussed surgery. There are no further medical records following, just one month after the injury, that discusses the claimant complaints, findings or ongoing treatment. ODG Guidelines document the use of rotator cuff repair surgery, biceps tendon surgery and impingement surgery in claimants who have positive physical findings, abnormal diagnostic testing and have failed appropriate conservative care for three months. In this case, there is no documentation of a clear full thickness rotator cuff tear and not clear documentation of significant long head biceps tendon abnormality, that is the tendon that is usually operated on if someone has a biceps issue. Plus there is not documentation of any conservative care more than a month and two physical therapy visits is not a true test of conservative care. In light of the fact that the only treatment records provided are for one month after the injury and there is no clear description of good appropriate conservative care coupled with the fact that there is no evidence of a true long head biceps tendon abnormality or significant rotator cuff injury then the reviewer finds that the requested Left shoulder arthroscopy, SAD, RTC repair arthrotomy debridement biceps repair is not medically necessary.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter shoulder, rotator cuff repair

ODG Indications for Surgery| -- Rotator cuff repair

Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out

1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS

2. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS

3. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary views. 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)