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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 03/04/2010

IRO CASE #:

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

This case was reviewed by a Orthopaedic Surgery, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder rotator cuff repair with biceps tendon repair

REVIEW OUTCOME

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

Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- 01-05-10 Initial PT assessment from PT and PT visits 1-6 through 01-16-10, 8 pp
- 01-11-10 Status Report: Follow-up Evaluation from Dr.
- 01-18-10 Orthopedic report from Dr.
- 01-07-10 Right shoulder MRI read by Dr.
- 01-19-10 Status Report: Follow-up Evaluation from Dr.
- 01-22-10 PT reevaluation report from PT and PT visits 6-12 through 02-02-10.
- 01-27-10 Request for pre-authorization letter from Dr.
- 01-27-10 Utilization review Referral from Dr.
- 02-02-10 Orthopedic report from Dr.
- 02-02-10 Adverse Determination letter
- 02-23-10 Adverse Determination letter on Reconsideration
- 02-25-10 Request for IRO from the Claimant
- 02-26-10 Confirmation of Receipt of Request for IRO from TDI
- 03-01-10 Notice of Case Assignment for IRO from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male employee who sustained an industrial injury to the right shoulder on xx/xx/xxxx when he slipped on a ladder while lifting an aluminum sheet.

The patient was assessed in PT on January 5, 2010. The patient operates a machine that cuts and bends metal sheets. He felt pain while pulling metal sheets overhead. He reports a pain level of 8/10. MRI has been ordered. Right shoulder flexion is to 141/180 and abduction to 148/180. He is tender at the right shoulder superior and anterior aspects. Treatment content appears to be primarily active with instruction in HEP. On January 6, 2010 PT notes state he is having difficulty raising his arms above 90 degrees.

The physician report of January 11, 2010 notes the patient's range of motion has increased and his extremity strength has

improved. X-rays were negative for fracture or dislocation. MRI shows supraspinatus tear. He should continue PT for ROM.

Right shoulder MRI was performed on January 7, 2010 and was provided impression: "Tear at the rotator cuff interval.

Intratendinous signal abnormality within the supraspinatus, suggestive of full thickness tear. No evidence of retraction or atrophy. Mild degenerative arthropathy of the AC joint. No evidence of impingement."

At PT visit number 6 on January 14, 2010 the patient is noted to be keeping his arm in a guarded position. PT content is active.

The patient was reevaluated orthopedically on January 18, 2010. The patient has undergone PT, MRI and pain medication without resolution of his right shoulder rotator cuff tear. He needs to be treated with a surgery. He has smoked for 15 years. On examination, no swelling or effusion is seen. There is no tenderness or crepitus. He has a 2+ impingement sign. 2+ Speed test and 2+ O'Brien test. Muscle strength is 4+/5 with elevation which is painful. Other muscle groups demonstrate full strength without note of pain. MRI impression is tear at the rotator cuff interval, intratendinous signal abnormality within the supraspinatus, suggestive of full thickness tear. Recommendation is for arthroscopic subacromial decompression, athroscopic rotator cuff repair and arthroscopic biceps tenodesis.

The patient returned to his physician on January 19, 2010. The patient states overall his symptoms have decreased. He reports a pain level of 4/10. Upper extremity range of motion has remained the same although his weakness has decreased. He should continue PT and Feldene 20 mg #10.

At PT visit number 6 on January 20, 2010 the patient is able to perform the treatments without exacerbation, he is improving. He is (has been) recommended for surgery with SAD, RC repair and biceps tenodesis.

The patient was reassessed in PT on January 22, 2010. Shoulder flexion is to 147 degrees and abduction to 139 degrees. Internal rotation has regressed from initial 67 degrees to 60 degrees and external rotation has remained the same at 61 degrees. Pain limits movements. He has difficulty with essential functions. A surgery has been recommended. He will continue PT.

On January 27, 2010 request was made for surgery to the right shoulder with rotator cuff repair, biceps tenodesis, subacromial decompression and any other indicated procedures. Post-op DME was requested of a cold therapy unit (Cryo-Cuff unit) for 7 days and a CPM unit for 10 days (or 14 days) rental and a shoulder sling.

PT visit number 12 notes of February 2, 2010 state the patient's pain is limiting daily activities. He will be out of therapy secondary to a death in the family. He is waiting for surgery to be scheduled.

According to the orthopedic reevaluation report of February 2, 2010 the patient is 6 weeks post injury with persisting right shoulder pain and weakness. He is unable to do his regular work or lift his grandchildren. He feels that therapy at this point is aggravating the shoulder. Right shoulder examination ntoes tenderness at the iceps tendon and interval, supraspinatus, rotator cuff interval, no swelling or crepitus, no deformity and no atrophy. Passive ROM is normal and symmetrical. Impingement signs are notes as 2+ primary, 2+ secondary, abduction is 2+ (painful), and there is 2+ with pain with Speeds, Serratus and O'Brien tests. Muscle strength is 4+/5 for elevation. Other motor groups are normal. Elevation and external rotation are painful. MRI is cited. Surgery was discussed with the patient. If he desires the surgery, a surgery will be requested.

Request for right shoulder arthroscopy was considered in review on February 2, 2010 with recommendation for non-certification. 5 pages of records were reviewed. A peer discussion took place with the PA. The request was not certified as no imaging study was available to clarify the reported rotator cuff tear. Also the patient has not been reported to have been provided a cortisone injection resulting in temporary relief as required by ODG. Additionally no PT notes were submitted to clarify this treatment. The physical examination also does not document ranges of motion and it is unknown if there is weakness or absent abduction. Also, the cited MRI results do not indicate a biceps tendon tear. In the discussion, no additional information was made available.

Request for reconsideration for right shoulder rotator cuff repair with biceps tendon repair was considered in review on February 23, 2010 with recommendation for non-certification. 34 pages of records were reviewed. The patient has had PT with some improvement noted. A radiology and/or MRI report were not included in the records. The submitted records did not include a complete physical examination. In peer discussion, the provider clarified that he was not planning a biceps tendon repair but a biceps tendon tenodesis which is commonly associated with rotator cuff repair procedures. It was recommended the provider submit a request for right shoulder rotator cuff repair with biceps tenodesis (rather than biceps repair) in the context of an appeal. The request was not certified.

Request was madder for an IRO.

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

ODG criteria for rotator cuff repair, objective 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). ODG criteria for ruptured biceps tendon surgery: Classical appearance of ruptured

muscle. ODG criteria for decompression surgery - objective 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.
The first line reviewer recommended non-certification with rationale that an imaging study was not available to clarify the reported rotator cuff tear. Also the patient was not reported to have been provided a cortisone injection resulting in temporary relief as required by ODG. Additionally no PT notes were submitted to clarify the treatment and the physical examination did not document ranges of motion or clarify weakness or absent abduction. Also, the cited MRI results did not indicate a biceps tendon tear.
The second line reviewer recommended non-certification with rationale that a radiology and/or MRI report were not included in the records and a complete physical examination was not documented. In peer discussion, the provider clarified that he was not planning a biceps tendon repair but a biceps tendon tenodesis which is commonly associated with rotator cuff repair procedures. It was recommended the provider submit a request for right shoulder rotator cuff repair with biceps tenodesis (rather than biceps repair) in the context of an appeal.
An official MRI report has been submitted which documents a tear at the rotator cuff interval, abnormal signal within the supraspinatus suggestive of full thickness tear and no evidence of retraction or atrophy. There is mild degenerative arthropathy of the AC joint and no evidence of impingement. Treatment has included a course of PT without significant improvements in range of motion; in fact, some regression is noted. Some decreased weakness has been noted but muscle strength remains 4+/5 for shoulder elevation. A thorough physical examination was documented, most recently with PT reassessment of January 22, 2010: Shoulder flexion is to 147 degrees and abduction to 139 degrees. Internal rotation has regressed from initial 67 degrees to 60 degrees and external rotation has remained the same at 61 degrees. Pain limits movements. He has difficulty with essential functions.
MRI does not show evidence of impingement as required by ODG to proceed with subacromial decompression. However, MRI does show a tear at the rotator cuff interval, with abnormal signal within the supraspinatus suggestive of full thickness tear. The provider has clarified that the plan is for a biceps tendon tenodesis not a biceps tendon repair, although MRI is often not accurate with biceps tendon injuries and there is always a possibility of biceps tenodesis seen at the time of operation. Given the imaging findings, surgery is definitely indicated for this patient.
Therefore, recommendation is to disagree with the previous non-certification of the request for right shoulder rotator cuff repair with biceps tendon repair.
The IRO's decision is consistent with the following guidelines:

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

__X___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

The Official Disability Guidelines - Shoulder Chapter (02-12-2010) Rotator Cuff Repair Surgery :

Recommended as indicated below. Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, but the outcomes from open repair are as good or better. Surgery is not indicated for patients with mild symptoms or those who have no limitations of activities.

ODG Indications for Surgeryä -- 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.
Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR 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.

The Official Disability Guidelines - Shoulder Chapter (02-12-2010), Surgery for Biceps tendon Repair 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.

ODG Indications for Surgeryä -- 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.

The Official Disability Guidelines - Shoulder Chapter (02-12-2010), Surgery for Impingement:

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.

ODG Indications for Surgeryä -- 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.