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Notice of Independent Review Decision

DATE OF REVIEW: 3/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The service in dispute is the medical necessity of a right shoulder poss RCR, Subacr, decomp capsular release/etc (29827, 9825, 29826, 29828).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a right shoulder poss RCR, Subacr, decomp capsular release/etc (29827, 9825, 29826, 29828).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source):
Records reviewed: preauth request undated, 2/2/10 notes from clinic, 1/7/10 right shoulder MRI report, 2/9/10 denial letter and report by MD.

Dr. All records received were previously received from the carrier.

We did not receive any WC Network Treatment Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was status post treatment with medications and therapy for the diagnosis of impingement syndrome. An MRI dated 2/2/10 revealed that there was a SLAP tear with biceps tendon extension, along with arthrosis and a partial cuff tear. The injury mechanism included overhead lifting. The rationale for the denial included inadequate documentation of a comprehensive non-operative program. The 3/3/10 dated reconsideration/denial letter was noted to have inadequately detailed therapy and medication responses to specified treatments. Treatment records from the AP were reviewed and dated 2/2/10. Three months of painful shoulder catching with popping was noted. Bicipital groove tenderness, painful and limited motion, positive impingement test and painful drop arm testing were all noted. Proposed surgical intervention with CPT codes was noted. The MRI dated 2/2/10 revealed the above findings along with a down sloping acromion, adhesive capsulitis and that the cuff tear was on the bursal/acromial side.

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

Considering the multiplicity of pathologies within the affected shoulder, there has been sufficient evidence of a reasonable attempt to have treated this individual non-operatively. The claimant has documented arthrosis of both the AC and glen humeral joints. Cortisone injection treatment would have been potentially expected to have (at best) decreased symptoms for a week or so and to have (at worst) increased softening of already soft and arthritic cartilage. The claimant's adhesive capsulitis/markedly restricted motion hadn't responded to therapy that was highly likely to have been specifically designed to decrease pain and improve motion. Medications would have been/were ineffective for a shoulder that was torn in many areas, including the labrum and rotator cuff. The claimant has multiple surgical lesions, including the impinging subacromial region, the SLAP and rotator cuff tears, the biceps pathology and the tight shoulder joint (capsuloligamentous structures.) Therefore the requested treatment is medically necessary at this time, of course with applicable procedure codes for multiple procedures being performed at the same setting.

Reference: ODG Guidelines

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.

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.

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.

Surgery for SLAP lesions	Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See <u>SLAP lesion diagnosis</u> . The advent of
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shoulder arthroscopy, as well as our improved understanding of shoulder anatomy and biomechanics, has led to the identification of previously undiagnosed lesions involving the superior labrum and biceps tendon anchor. Although the history and physical examinations as well as improved imaging modalities (arthro-MRI, arthro-CT) are extremely important in understanding the pathology, the 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. (Nam, 2003) (Pujol, 2006) (Wheeless, 2007)

Surgery for adhesive capsulitis

“...there is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment. (Dudkiewicz, 2004) (Guler-Uysal, 2004) (Castellarin, 2004) (Berghs, 2004)”

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. 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.

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
- 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)