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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/18/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopy of the Right Shoulder with Decompression, Clavicle Excision, Biceps Tenodesis and Debridement

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)

The reviewer finds that Arthroscopy of the Right Shoulder with Decompression and Debridement is medically necessary.

The reviewer finds that Clavicle Excision, Biceps Tenodesis is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Rehab note, 8/21/09

MRI right shoulder, 10/26/09

Office note, Dr., 10/30/09

Office notes, Dr., 11/06/09, 11/20/09, 01/06/10

Peer review, Dr., 01/13/10

Peer review, Dr., 01/25/10

PATIENT CLINICAL HISTORY SUMMARY

This is a female with complaints of right shoulder pain. The MRI of the right shoulder from 10/26/09 showed partial thickness tears along the bursal and articular surface of the supraspinatus tendon without definite evidence of full thickness tear. There was a mild amount of fluid in the subacromial subdeltoid bursa. There was suggestion of Buford complex with thickened middle glenohumeral ligament. There was a partial thickness tear involving the anterior mid labrum. Focal grade II/III chondromalacia involving the glenoid was noted. Type II acromion lending to minimal impingement on the supraspinatus tendon was reported. On 11/16/09, Dr. performed an injection. On 11/20/09, the claimant reported no relief from the injection. Dr. evaluated the claimant on 01/06/10. Examination revealed positive impingement, Hawkins and Jobe's testing. Diagnosis was rotator cuff syndrome. The claimant has been treated with Vicodin, light duty, injection, rest, physical therapy and prednisone.

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

This is a woman who has had ongoing right shoulder pain and limitations in function since a fall down stairs on xx/xx/xx. The medical record documents an MRI with rotator cuff pathology and impingement, yet none of the medical records document any acromioclavicular joint complaints, abnormal physical findings, or acromioclavicular joint abnormal testing. The medical record does not document any biceps tendon complaints, biceps physical findings or biceps tendon abnormalities on diagnostic testing.

This claimant has failed appropriate conservative care for impingement, and has evidence of partial rotator cuff tearing. ODG Guidelines, document the use of subacromial decompression and impingement surgery in claimants who have abnormal MRI testing positive physical findings and failure of appropriate conservative care, which have all occurred in reference to the impingement. For these reasons, the reviewer finds that Arthroscopy of the Right Shoulder with Decompression and Debridement is medically necessary.

There is no documentation in the medical record of positive physical findings, complaints, or abnormal diagnostic testing with regard to the acromioclavicular joint or biceps tendon. The reviewer finds that Clavicle Excision, Biceps Tenodesis is not medically necessary, as these procedures do not meet the ODG criteria for surgical intervention.

The reviewer finds that Arthroscopy of the Right Shoulder with Decompression and Debridement is medically necessary. The reviewer finds that Clavicle Excision, Biceps Tenodesis is not medically necessary.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter shoulder, acromioplasty, biceps tenodesis

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

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

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)

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)