

# Core 400 LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Oct/27/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Right Shoulder Arthroscopy, rotator cuff, with labral repair and AC joint resection with 23 hr stay

**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**

09/13/10, 10/07/10 Inc.  
07/06/10 right shoulder x-ray report  
07/08/10 MRI right shoulder report  
07/06/10, 07/13/10, 07/20/10 office notes  
08/02/10 and 08/30/10 physical therapy notes  
09/01/10, 09/23/10 Dr. office note  
09/07/10 surgical request  
09/13/10, 10/07/10 peer reviews  
ODG Treatment Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male with complaints of right shoulder pain after a lifting injury on xx/xx/xx. The MRI of the right shoulder dated 07/08/10 showed a small focal articular side tear involving the distal anterior supraspinatus tendon. Mild osteoarthritic changes of the acromioclavicular joint with predominately downward projecting osteophytes which were noted to contract the distal supraspinatus muscle and may contribute to impingement symptoms were reported. There was a type II acromion without significant inferolateral acromial tilt. Dr. evaluated the claimant on 09/01/10. Shoulder range of motion was limited. There was supraspinatus isolation weakness and positive impingement. The diagnoses were right shoulder impingement and a sprained supraspinatus tendon. On 09/23/10, Dr. saw the claimant. Right shoulder range of motion was restricted. There was marked supraspinatus weakness

and a positive impingement sign. Crossed chest test was positive. Dr. stated that the claimant has refused injection medical management and additional physical therapy. The claimant has been treated with physical therapy, Norco, Naprelan and work restrictions.

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

The requested Right Shoulder Arthroscopy, rotator cuff, with labral repair and AC joint resection with 23 hr stay is not medically necessary based on the information reviewed.

The claimant does not have a full-thickness tear according to the MRI of 07/08/10. The report states that the claimant has only a "small focal articular sided tear involving the distal anterior supraspinatus tendon." The claimant does not appear to have a high-grade partial tear or significant tear that would warrant surgery without a thorough course of conservative treatment.

The only conservative treatment documented for this claimant was six visits of physical therapy and medications. The claimant has not attempted a full course of therapy, and the claimant has refused a corticosteroid injection, although many patients with partial rotator cuff pathology have symptomatic inflammatory bursitis or impingement that responds favorably to the anti-inflammatory effects of a corticosteroid injection. The surgeon appears to have requested the surgery on the basis that the claimant has refused additional conservative care. The refusal of conservative care when there is a chance of success in avoiding surgery is inadequate justification to proceed with surgery. Though this claimant may ultimately fail conservative measures and require an operation, ODG evidence-based guidelines recommend a thorough course of conservative care before pursuing surgery in this setting.

The requested Right Shoulder Arthroscopy, rotator cuff, with labral repair and AC joint resection with 23 hr stay is not medically necessary based on the information reviewed.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter shoulder, rotator cuff repair, classification of a SLAP lesion and surgery for SLAP tear

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.

Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. The advent of 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.

Criteria for Classification of SLAP lesions:

- Type I: Fraying and degeneration of the superior labrum, normal biceps (no detachment); Most common type of SLAP tear (75% of SLAP tears); Often associated with rotator cuff tears; These may be treated with debridement.
- Type II: Detachment of superior labrum and biceps insertion from the supra-glenoid tubercle; When traction is applied to the biceps, the labrum arches away from the glenoid; Typically the superior and middle glenohumeral ligaments are unstable; May resemble a normal variant (Buford complex); Three subtypes: based on detachment of labrum involved anterior aspect of labrum alone, the posterior aspect alone, or both aspects; Posterior labrum tears may be caused by impingement of the cuff against the labrum with the arm in the abducted and externally rotated position; Type-II lesions in patients older than 40 years of age are associated with a supraspinatus tear whereas in patients younger than 40 years are associated with participation in overhead sports and a Bankart lesion; Treatment involves anatomic arthroscopic repair.
- Type III: Bucket handle type tear; Biceps anchor is intact
- Type IV: Vertical tear (bucket-handle tear) of the superior labrum, which extends into biceps (intrasubstance tear); May be treated with biceps tenodesis if more than 50% of the tendon is involved. (Wheeless, 2007)

**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)