

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/31/2010

**IRO CASE #:**

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

Left Shoulder Arthroscopic Debridement/Slap Lesion 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

Adverse Determination Letters, 8/5/10, 7/26/10

Office notes Dr. 12/01/06, 12/08/06

Left shoulder x-rays 12/01/06

Office notes Dr. 12/12/06, 01/02/07, 02/09/07, 06/28/07, 07/15/10

MRI left shoulder 12/20/06

MRI left shoulder 07/08/10

Peer review, Dr. 07/26/10

Letter of appeal Dr. 07/29/10

Peer review Dr. 08/05/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male who injured his shoulder. The left shoulder x-rays showed moderate degenerative arthritic change. The MRI of the left shoulder, dated xx/xx/xx, revealed severe glenohumeral joint degenerative joint disease with osteophytosis and erosive change. There was associated degenerative labral tearing. There was posterior subluxation of the humerus relative to glenoid, consistent with capsular laxity. There was hypertrophic tendinosis of the rotator cuff although no high-grade rotator cuff tear. There was a type II acromion. The claimant was treated with injection, NSAIDS and light duty. The claimant was released to full duty on 02/09/07. Dr. evaluated the claimant on 06/28/10 for an exacerbation of shoulder pain. Examination revealed pain with elevation past 90 degrees, positive impingement finding and pop with O'Brien test thumb down. X-rays of the shoulder that day showed inferior bone

spurs in the glenohumeral joint. The MRI of the left shoulder, dated 07/08/10, revealed severe osteoarthritis change in the shoulder and laxity of the rotator cuff with posterior subluxation of the humeral head. There was no rotator cuff tear. The body of report documented a labral tear. On 07/15/10, Dr. stated that the MRI showed posterior labral tear, osteoarthritis of the glenohumeral joint and no loose body. Dr. has recommended an arthroscopic debridement.

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

The requested left shoulder arthroscopy and debridement of SLAP lesion cannot be justified as medically necessary based on the information reviewed and the ODG. Previous x-rays and MRI from 2006 showed severe glenohumeral degenerative arthritis with osteophytes and posterior subluxation of the humerus relative to the glenoid. Though prior MRI studies indicate degenerative labral pathology or tearing, the records indicate the claimant's primary pathology appears to be end stage severe arthritis of the glenohumeral joint. Previous records indicated no mechanical symptoms to suggest a symptomatic labral tear. The rationale for debridement of a SLAP lesion in the presence of end-stage arthritis is unclear. Records indicate this claimant has chronic arthritic change of the glenohumeral joint for many years. Given the severe arthritic change and posterior subluxation noted, it is not clear that a debridement of a SLAP lesion or arthroscopic debridement would provide any significant sustained relief. The reviewer finds that medical necessity does not exist for Left Shoulder Arthroscopic Debridement/Slap Lesion Repair.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter shoulder, surgery for SLAP Lesion and Criteria for Classification of SLAP lesion

Surgery for SLAP Lesion: Recommended for Type II lesions and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. 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. (Wheless, 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)