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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: August 24, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

One left shoulder biceps tendon tenodesis, one purchase of cold therapy unit, and one purchase of abduction sling

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 Treatment in Worker's Comp, Shoulder

MRI left shoulder: 11/23/10

Surgical Report: 02/22/11

PT Progress Notes: 04/11/11, 4/13/11, 06/01/11

Dr. OV: 06/06/11, 7/1/11

Worker's comp Authorization Request: 06/06/11

Peer Reviews: 06/22/11, 07/06/11

Claimant Appeal for Review: 06/27/11

Addendum to Request for Independent Review, 08/02/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who sustained a work related injury to his left shoulder onxx/xx/xx. The claimant was walking through a when he tripped over a drum and fell on his shoulder. The claimant underwent an Arthroscopic rotator cuff repair, subacromial decompression and arthroscopic debridement on 02/22/11. Postoperatively the claimant ruptured his left long head biceps tendon as he was reaching up to remove an item form a shelf. Dr. recommended a biceps tendon tenodesis and postoperatively a cold unit and abduction pillow sling. The surgery has been noncertified in two peer reviews dated 06/22/11 and 07/06/11. The cold unit and abduction pillow have also been noncertified.

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

The reviewer finds there is not a medical necessity for one left shoulder biceps tendon tenodesis, one purchase of cold therapy unit, and one purchase of abduction sling. ODG guidelines do not recommend this surgery – the guidelines state that nonsurgical treatment is

usually all that is needed for biceps tendon tear according to the evidence-based guidelines. The guidelines also state that if the surgery is to be performed that the patient should be a young adult and that this procedure is not recommended as an independent stand alone procedure. The requests for purchase of a cold therapy unit and purchase of abduction sling are not medically necessary. Continuous flow cryotherapy is typically recommended up to 7 days postoperative and is not recommended for nonsurgical treatment. Likewise, an abduction pillow sling is recommended as an option following open repair of large and massive rotator cuff tears, not in nonsurgical cases or for arthroscopic repairs. The request for one left shoulder biceps tendon tenodesis, one purchase of cold therapy unit, and one purchase of abduction sling is not supported in the evidence based Official Disability Guidelines.

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)