

CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 14, 2011 **Amended:** August 19, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Rt Shoulder Subacromial Decompression Debridement Biceps Tenodesis-Ten

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

This physician is a Board Certified Orthopedic Surgeon with over 40 year of experience.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

7/27/09: M.D. evaluated the claimant.

8/1/09: M.D. evaluated the claimant.

8/3/09: M.D. evaluated the claimant.

8/3/09: MR Arthrogram of the shoulder.

8/3/09: MRI of the Right Shoulder.

8/13/09: M.D. evaluated the claimant. Impression: Right shoulder rotator cuff tear.

8/27/09: M.D. evaluated the claimant.

9/24/09: M.D. performed an EMG/NCV.

10/12/09: M.D. evaluated the claimant.

3/4/10: M.D. evaluated the claimant.

3/18/10: M.D. evaluated the claimant.

4/19/10: M.D. evaluated the claimant.

5/5/10: M.D. evaluated the claimant.

5/7/10: M.D. performed an arthroscopy right shoulder with subacromial decompression right shoulder.

5/17/10: M.D. evaluated the claimant.

6/14/10: MRI of Right Shoulder was performed. Impression: Moderate subacromial subdeltoid bursitis status post acromioplasty new since the last exam. Persistent tendinosis of the supraspinatus tendon. No evidence of full thickness rotator cuff tear or labral injury.

8/19/10: M.D. evaluated the claimant.

9/27/10: M.D. evaluated the claimant.

10/25/10: M.D. evaluated the claimant.

11/29/10: M.D. evaluated the claimant.

1/18/11: M.D. evaluated the claimant.

4/19/11: M.D. evaluated the claimant.

5/2/11: M.D. performed a DDE on the claimant.

5/26/11: MR Arthrogram Shoulder. Impression: Mild AC joint degenerative change. Post-surgical change of acromioplasty.

6/6/11: M.D. evaluated the claimant.

6/22/11: M.D. performed a UR on the claimant. Rationale for Denial: MR Arthrogram of the shoulder did not reveal any abnormality in the biceps tendon to warrant debridement.

7/12/11: M.D. evaluated the claimant.

7/20/11: M.D. performed a UR on the claimant. Rationale for Denial: No documentation of specific conservative treatment.

PATIENT CLINICAL HISTORY:

The claimant injured while pulling a box at work.

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

The previous decisions are upheld. The MR Arthrogram of the shoulder performed on 6/22/11 did not reveal any abnormality in the biceps tendon; therefore the claimant's condition does not warrant surgical intervention per the ODG Guidelines.

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.

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)