

SENT VIA EMAIL OR FAX ON
May/27/2011

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/26/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient right shoulder latissimus dorsi transfer with 23 hour observation

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

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

OD Guidelines

1. MRI right shoulder dated 03/10/10
2. Clinical records Dr. dated 04/27/10-04/12/11
3. Operative report dated 06/04/10
4. MRI right shoulder dated 02/01/11
5. Utilization review determination dated 04/22/11
6. Utilization review determination dated 05/03/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries to his right shoulder on xx/xx/xx. It is reported the claimant fell sustaining injury to right shoulder. On 03/10/10 the claimant was referred for MRI of the right shoulder. This study notes a large full thickness tear extending to the supraspinatus and infraspinatus tendons which are retracted several cm with considerable atrophy of the muscles. He is noted to have a type III acromion with some narrowing of interspace between humeral head and acromion arch. There is

prominent osteophyte along undersurface of acromion. The AC joint is hypertrophied with moderate sized superior and inferior marginal osteophyte. There is some blunting of superior aspect of the labrum. Records indicate the claimant came under the care of Dr. on 04/27/10. The claimant reports pain to affected right shoulder. He reported feeling weak. It pops and grinds. He has difficulty with reaching and activities of daily living. He is reported to have received injection. His current medications include Alipurinol and Coumadin. Physical examination indicates he is in no apparent distress. He has diffuse tenderness over the shoulder. Range of motion with forward flexion is to 80 degrees, abduction is to 60, external rotation is to 20. Jobe's test was positive for weakness. External rotation lag sign was positive. Radiographs of right shoulder are reported to be unremarkable and show type II acromion. MRI is discussed. It was recommended the claimant undergo arthroscopic rotator cuff repair with subacromial decompression.

Records indicate the claimant was taken to surgery on 06/04/10 at which time he underwent right shoulder rotator cuff repair, arthroscopic biceps tenodesis, subacromial decompression, and debridement of type II superior, anterior, and posterior labral regions. Postoperatively the claimant was referred for physical therapy.

On 07/15/10 it is reported the claimant has decreasing shoulder pain with increased shoulder range of motion and strength. Elevation is to 90 degrees. Shoulder external rotation is to 20.

On 09/16/10 the claimant is reported to have forward flexion to 120 degrees, abduction to 120 degrees, and external rotation to 25. The claimant was to continue in physical therapy. Records indicate the claimant has reached limits of physical therapy. The claimant was subsequently recommended to undergo MR arthrogram of the right shoulder. This study performed on 02/01/11 indicates a complete full thickness recurrent tear of supraspinatus tendon with 4 cm of retraction with mild muscle belly atrophy. There appears to be a full thickness tear of infraspinatus with retraction and marked fatty infiltration and atrophy of the infraspinatus muscle belly. There is a focal full thickness tear involving the superior third of distal subscapularis tendon. There is diffuse labral degeneration with mild degeneration of AC joint.

The claimant was seen in follow-up by Dr. on 04/12/11. He has had no changes in his symptoms from prior visit. He continues to have diffuse tenderness of shoulder. Active range of motion is unchanged from previous examinations. Treatment options were discussed including nonoperative versus debridement, versus lat transfer. The claimant subsequently is recommended to undergo latissimus dorsi transfer.

On 04/22/11 the request was reviewed by Dr.. Dr. notes the claimant's history. Dr. reports there was little detail in the notes to attest why the physician is moving onto this alternative surgery. He finds there is little evidence in the records to support certification of request. He notes latissimus dorsi tendon transfer is performed to reduce pain and weakness in patients with massive irreparable infraspinatus and supraspinatus tendon tears. He notes that the latissimus dorsi transfer is not considered an alternative for rotator cuff repair but as a reconstructive procedure if repair of a posterior lateral cuff defect is not possible. Full restoration of function is not typically a result of this surgery.

On 05/03/11 the case was reviewed by Dr.. Dr. notes that there is a full thickness tear that is retracted to the glenoid rim that obviously would not be a reparable type lesion. He reports that the latissimus dorsi transfer is medically indicated for irreparable rotator cuff tears. He notes that it is recommended to perform rotator cuff reconstruction and when the tear defects are not reparable partial repair has shown decreased strain at the free margin resulting in improved function. He notes additionally if necessary tendon transfer can be used to treat residual defect with latissimus dorsi used in patients with posterior superior tear with weak external rotation. He notes that with the documentation submitted there is insufficient evidence as to the injured employee's function that would support the need for latissimus dorsi transfer.

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

The request for latissimus dorsi transfer with 23 hours observation is not supported by the submitted clinical information and the previous determinations are upheld. The records indicate that the injured employee initially sustained a significant rotator cuff tear through the supraspinatus and infraspinatus tendons as a result of a slip and fall. The injured employee was taken to surgery on 06/04/10 and underwent extensive surgery to repair these defects. Records indicate that the claimant was progressing in his post operative treatment with improvements in range of motion and decreased pain levels. He was noted to have complaints of numbness and headaches since the injury. His range of motion was stable. The limited information indicates that Dr. somehow felt the claimant had a recurrent tear and referred the injured employee for MR arthrogram. This study showed significant recurrent tears with retraction that would not be reparable or potentially are not reparable through standard surgery. He subsequently recommended a salvage procedure involving latissimus dorsi transfer. The records are devoid of data establishing the injured employee's current functional status. There are no physical therapy records submitted. There is a clear lack of insight as to the selection of this procedure and given the lack of data the medical necessity of the request was not established. Previous decisions remain upheld.

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)