

Prime 400 LLC

An Independent Review Organization
240 Commercial Street, Suite D
Nevada City, CA 95959
Phone: (530) 554-4970
Fax: (530) 687-9015
Email: manager@prime400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Shoulder Arthroscopy with debridement with poss RTC repair and biceps tendon 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

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained a work related injury to her left shoulder on xx/xx/xx. The initial diagnosis was not provided. The claimant had a right shoulder diagnostic arthroscopy with bursectomy, resection of adhesions and open biceps tenodesis on 10/07/10. An MRI of her left shoulder on 03/15/10 documented acromioclavicular joint arthrosis and rotator cuff and biceps tendinosis. On examination, when she saw Dr. on 12/09/10, the claimant had tenderness to palpation in the left shoulder bicipital region, a positive Yergason's test and a positive Crank test. She was noted to have fair strength to flexion and abduction. It was noted that she had failed physical therapy and had not gotten good relief from a cortisone injection (no date given). Dr. recommended surgery to her left shoulder which has been noncertified by two peer reviews.

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

The surgery (Left Shoulder Arthroscopy with debridement with poss RTC repair and biceps tendon repair) has been denied on two peer reviews, 02/08/11 and 03/09/11. The diagnoses are that of rotator cuff tendinitis, biceps tendinitis, moderate acromioclavicular joint arthrosis. The date of injury was xx/xx/xx. The claimant had a right shoulder arthroscopy performed in the past. Regarding the left shoulder, an MRI was obtained 03/15/10, greater than a year ago, demonstrating acromioclavicular joint arthrosis as well as tendinosis. The claimant was seen by Dr. 12/09/10. She had tenderness over the biceps region, a positive Yergason test and a positive crank test. She had fair strength. It was noted that she had failed conservative treatment consisting of physical therapy and had not gotten good relief from a

cortisone injection. Official Disability Guidelines would be referenced for this case. The chief diagnosis appears to be impingement syndrome. The claimant's symptoms have been present for a year. Conservative treatment has been outlined consisting of physical therapy as well as an injection. Her subjective complaints would be consistent with shoulder pain with impingement syndrome. The claimant has positive physical findings with tenderness over the biceps region, positive Yergason test, and positive crank test. She has weakness.

There is also evidence of moderate degenerative changes of the acromioclavicular joint. The claimant has failed to respond to conservative treatment including therapy and an injection and has ongoing complaints of pain with positive findings on the MRI. The reviewer finds there is a medical necessity for Left Shoulder Arthroscopy with debridement with poss RTC repair and biceps tendon repair.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates.
Shoulder:

Surgery for impingement syndrome

ODG Indications for Surgery | -- Acromioplasty

Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery).

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS
3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement.

Surgery for ruptured biceps tendon (at the shoulder):

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-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)