



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 12-22-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder scope with open biceps tenodesis acromioplasty and bursa removal with 23-hour observation stay between 10/31/11 and 12/30/11

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

American Board of Orthopaedic Surgery-Board Certified

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

- Chiropractic Therapy on 2-16-11, 2-21-11, 3-2-11, 4-11-11, 4-31-11.
- 4-11-11 MRI of the right shoulder without contrast performed by.
- 6-15-11, office visit.
- Work Hardening Program at on 6-21-11, 6-22-11, 6-23-11, 6-27-11, 6-28-11, 6-29-11, 6-30-11, 7-5-11, 7-6-11, 7-7-11.
- 9-14-11, Impairment Rating.
- 10-19-11, office visit.
- 10-28-11, Medical Review.
- 11-7-11, Medical Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Chiropractic Therapy from 2-16-11 through 4-31-11 (5 sessions)

4-11-11 MRI of the right shoulder without contrast performed by, showed postoperative changes from a previous subacromial decompression. Metallic susceptibility artifact in the proximal humeral head may reflect previous rotator cuff repair or biceps tenodesis. Rotator cuff tendons are preserved. No tear of the supraspinatus is identified. Full-thickness tear of the long head of biceps tendon. Fraying of the superior aspect of the labrum without a tear. Small effusion in the subscapularis recess.

6-15-11, the claimant presents today in regard to history of injury of the right shoulder on 2-1-11. This was a job-related injury when he was drug by a rope he grabbed onto. The claimant has had pain in the right shoulder since that time. He does have a prior history of surgery of the right rotator cuff in 2005. However, he relates that this problem had corrected itself and was no longer an issue or a problem. The claimant has had persistent pain in the right shoulder with weakness and popping. The claimant had an MRI of the right shoulder on 4-11-11. This shows that he has a tear of the long head of the biceps tendon. The rotator cuff is intact. Assessment: The claimant has a new injury of the right shoulder consisting of a tear of the biceps tendon. Plan: The claimant should have right shoulder arthroscopy with open biceps tenodesis. In addition, acromioplasty and bursa removal will be carried cut.

Work Hardening Program from 6-21-11 through 7-7-11 (10 sessions)

9-14-11, performed a Designated Doctor Evaluation. He certified the claimant had reached MMI on 8-23-11 and awarded the claimant 6% whole person impairment.

10-19-11, the claimant has been treated conservatively with therapy, medication and injections without relief. Assessment: Right shoulder biceps tendon tear. Plan: When he was previously seen on 6-15-11, the evaluator had recommended that he have shoulder surgery. However, this was denied. The MRI examination shows a tear of the biceps tendon. There is impingement of the shoulder as well. The evaluator still think the claimant needs to have the right shoulder surgery as previously recommended.

10-28-11, performed a Medical Review. It was his opinion based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines, this request for one right shoulder scope with open biceps tendolysis, acromioplasty and bursa removal with 23 hour observation stay is non-certified. He noted that as per report dated 10/19/11, the patient was diagnosed with right shoulder biceps tendon repair. On physical examination, there is pain and weakness in the right shoulder. There is lifting pain in forward flexion and rotation. He is not able to use the arm without pain. This is a request for right shoulder scope with open biceps tenolysis, acromioplasty and bursa removal with 23 hour observation stay. As per referenced guideline, indications for surgery include correlation of the patient's clinical signs and symptoms, radiographic imaging studies as well as conservative treatments. The most recent medical report does not contain a comprehensive neuromotor and physical examination. The patient underwent PT sessions; however, the clinical data did not objectively document the functional status of the patient in all these PT visits. At the same time, the records submitted for review failed to document exhaustion of other recommended conservative treatments such oral pharmacotherapy and cortisone injections. Furthermore, as per guideline, surgery is almost never considered in full thickness ruptures in the long head of biceps. There was also no documentation of deformity as well objective clinical findings of a ruptured muscle in the reports submitted for review. As such, the medical necessity of the proposed surgery has not been substantiated. Consequently, the 23 hour observation stay is likewise not established at this time.

11-7-11, performed a Medical Review. It was his opinion based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines, this appeal request for a Right Shoulder Scope with Open Biceps Tenodesis, Acromioplasty and Bursa Removal with 23-Hour Observation Stay between 10-31-11 and 12-30-11 is non-certified. He noted that records indicate that there was an adverse determination of a previous review. In acknowledgement of the previous non-certification due to lack of documentation of a recent physical examination including objective clinical findings of a ruptured muscle and additional conservative treatment; there is now documentation of additional conservative treatment including injections, PT, chiropractic treatment, electric muscle stimulation, and ice/hot packs. As per 10/19/11 medical report, the patient complains of continued pain and weakness in

the right shoulder. Physical examination revealed pain with forward flexion and rotation. Imaging findings include a 4/11/11 MRI of right shoulder identifying postoperative changes from a previous subacromial decompression, metallic susceptibility artifact in the proximal humeral head which may reflect a previous rotator cuff or biceps tenodesis; no tear of the supraspinatus is identified; full thickness tear of the long head of the biceps tendon; fraying of the superior aspect of the labrum without a tear; small effusion in the subscapularis recess. However, specifically regarding acromioplasty, despite documentation of objective findings including pain with forward flexion and rotation and conservative treatment including injections, there remains no (clear) documentation of additional subjective findings (pain at night), and additional objective findings (tenderness over rotator cuff or anterior acromial area, positive impingement sign, and temporary relief of pain with anesthetic injection [diagnostic injection test]). Furthermore, specifically regarding biceps tenodesis, given documentation of the 2/1/11 DOI, there remains no (clear) documentation of normal arm strength and that no more than 3 weeks have elapsed since date of injury. Therefore, the medical necessity of the request is not substantiated.

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

IT IS DIFFICULT TO INTERPRET THE MRI TO DETERMINE IF THE CLAIMANT HAS ANY ACUTE PATHOLOGY AFTER HE HAS HAD A ROTATOR CUFF REPAIR. THE CLAIMANT HAS HAD PHYSICAL THERAPY AND INJECTIONS BUT REMAINS SYMPTOMATIC. THEREFORE, IT IS REASONABLE TO PERFORM A DIAGNOSTIC ARTHROSCOPY WITH REPAIRS AS INDICATED. HOWEVER, REGARDING THE BICEPS TENODESIS, IT WOULD BE PRUDENT TO OBTAIN HIS PRIOR OPERATIVE REPORT TO DETERMINE WHAT WAS DONE DURING HIS PRIOR PROCEDURE. IF THE CLAIMANT HAD A PRIOR TENODESIS, THEN A REPEAT TENODESIS WOULD NOT BE WARRANTED. IF THIS IS A NEW FINDING AND IT OCCURRED DUE TO THE APRIL INJURY, IT IS LIKELY NO LONGER ABLE TO BE "TENODIZED." TYPICALLY, IF AFTER A TENDON RUPTURES, IT WOULD NO LONGER BE ABLE TO BE REPOSITIONED AFTER 6 WEEKS. THEREFORE, I DO NOT BELIEVE THAT THE OPEN BICEPS TENODESIS IS REASONABLE OR NECESSARY. AS IT RELATES TO THE REQUESTED ACROMIOPLASTY, THIS WAS LIKELY PERFORMED AT THE TIME OF HIS PRIOR ROTATOR CUFF REPAIR. THE NEED FOR REVISION ACROMIOPLASTY SHOULD BE DETERMINED AT THE TIME OF DIAGNOSTIC ARTHROSCOPY.

IN SUMMARY, THE REQUEST FOR RIGHT SHOULDER SCOPE AND ACROMIOPLASTY (IF INDICATED) WITH 23 HOUR OBSERVATION STAY BETWEEN 10-31-11 AND 12-30-11 WOULD BE REASONABLE AND MEDICALLY NECESSARY. HOWEVER, AN OPEN BICEPS TENODESIS AND BURSA REMOVAL DOES NOT APPEAR TO BE REASONABLE OR MEDICALLY NECESSARY AT THIS JUNCTURE.

ODG-TWC, last update 10-21-11 diagnostic arthroscopy: Recommended as indicated below. **Criteria** for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear. (Washington, 2002) (de Jager, 2004) (Kaplan, 2004)

ODG-TWC, last update 10-21-11 Occupational Disorders of the shoulder - surgery for ruptured biceps tendon: Not recommended except as indicated below. Nonsurgical treatment is usually all that is needed for tears in the proximal biceps tendons (biceps tendon tear at the shoulder). Surgery may be an appropriate treatment option for tears in the distal biceps tendons (biceps tendon tear at the elbow) for patients who need normal arm strength. (Mazzocca, 2008) (Chillemi, 2007) Ruptures of the proximal (long head) of the biceps tendon are usually due to degenerative changes in the tendon. It can almost always be managed conservatively, since there is no accompanying functional disability. Surgery may be desired for cosmetic reasons, especially by young body builders, but is not necessary for function. (Rantanen, 1999) When patients having rotator cuff surgery also have a torn biceps tendon, repairing it with tenodesis takes only 10 minutes longer than tenotomy but yields better outcomes. In tenodesis, the surgeon cuts the normal attachment of the biceps tendon on the shoulder socket and reattaches it to the humerus. This maneuver takes pressure off the cartilage rim of the shoulder socket (the labrum), and a portion of the tendon can be resected. The alternative, a tenotomy, simply involves cutting and suturing the tendon. With tenodesis, patients have a longer recovery, but they're also more likely to have better function and a normal appearing biceps muscle. With tenotomy, there can be arm cramping, weakness, and a biceps tendon abnormality called a "Popeye deformity". Tenodesis is a better approach except for the aged, senile, and less active. (Koh, 2010)

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.

(Washington, 2002)

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)**