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**Notice of Independent Review Decision**

**DATE NOTICE SENT TO ALL PARTIES:** 11/17/12

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of tenomyotomy shoulder, tenodesis long bicep tendon, arthroscopy shoulder, surgical repair of slap, extensive shoulder debridement, arthroscopy, shoulder, distal claviclectomy.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

**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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of tenomyotomy shoulder, tenodesis long bicep tendon, arthroscopy shoulder, surgical repair of slap, extensive shoulder debridement, arthroscopy, shoulder, distal claviclectomy.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: Dr. and xxxx.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: 9/12/12 office note, and 8/22/12 right shoulder MR and MR arthrogram report.

IMO: 9/18/12 denial letter and report, 8/7/12 to 8/28/12 office notes, 8/10/11 to 7/23/12 notes, and 10/19/12 denial letter and report.

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The XX year-old has reported a painful right shoulder since being injured while trying to put a sliding glass door back on its track. Clinical notes from the treating provider were also reviewed. Most recently on 9-13-12, there was a positive impingement sign along with a positive cross chest sign, There was tenderness at the AC joint and biceps tendon. An MRI/arthrogram dated 8 -22-12 has revealed a small synovial cyst, a small effusion and a subtle SLAP tear, along with tendinosis of the rotator cuff. Treatment to date has included medications, restricted activities and physical therapy. Denial letters have included the lack of a painful arc of shoulder motion, lack of definitive pathology noted on the shoulder MRI report, and, lack of detailed physical therapy notes and-or evidence of a trial of injection treatment at the level of the shoulder.

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

Applicable clinical guidelines only support the requested surgical intervention in the case of persistent subjective and objective findings and failure of reasonable non-operative treatment. In this case, temporary relief of pain with an anesthetic injection has not been documented. In addition, detailed physical therapy records with outcomes have not been provided. Finally, the MRI findings do not appear to be severe and-or associated with any definitive surgical indication. This is especially valid with the lack of adequate documentation and provision of a recent trial and failure of comprehensive non-operative treatment protocols, as referenced. Therefore the requested procedures do not appear to be medically reasonable and-or necessary at this time.

Reference: ODG Shoulder Chapter

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.

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.

ODG Indications for Surgery- SLAP lesions:

Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. The advent of shoulder arthroscopy, as well as our improved understanding of shoulder anatomy and biomechanics, has led to the identification of previously undiagnosed lesions involving the superior labrum and biceps tendon anchor. Although the history and physical examinations as well as improved imaging modalities (arthro-MRI, arthro-CT) are extremely important in understanding the pathology, the definitive diagnosis of superior labrum anterior to posterior (SLAP) lesions is accomplished through diagnostic arthroscopy. Treatment of these lesions is directed according to the type of SLAP lesion. Generally, type I and type III lesions did not need any treatment or are debrided, whereas type II and many type IV lesions are repaired. Shoulder surgery for SLAP tears may not be successful for many patients. For example, of pitchers who failed physical rehabilitation and then went on to surgery just 7% were able to play as well as they had before, but for

pitchers who just underwent physical rehabilitation, 22% were able to play as well as they previously had.

**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)