

Notice of Independent Review Decision

June 27, 2013

DATE OF REVIEW: June 27, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder diagnostic arthroscopy, subacromial decompression, subcoracoid decompression and bursectomy possible release of short head biceps and treatment

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

This case was reviewed by a board certified Orthopaedic Surgeon currently licensed and practicing in the State of Texas.

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)

Upheld: Subacromial decompression and possible release of short head biceps
Overturned: Right shoulder diagnostic arthroscopy and subcoracoid decompression

INFORMATION PROVIDED TO THE IRO FOR REVIEW

| Type of Document Received | Date(s) of Record |
|----------------------------------|--------------------------|
| Progress note | 09/18/2012 |
| Progress note | 09/27/2012 |
| Progress note | 10/26/2012 |
| Physical therapy notes | 10/31/2012 |
| Progress note | 11/07/2012 |
| Initial orthopedic evaluation | 11/15/2012 |
| Progress note | 11/21/2012 |
| Progress note | 12/12/2012 |



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| Progress note | 12/27/2012 |
| Progress note | 01/07/2013 |
| Progress note | 01/24/2013 |
| Progress note | 02/14/2013 |
| Progress note | 02/14/2013 |
| DD exam | 03/07/2013 |
| Progress note | 03/21/2013 |
| MRI of right humerus | 03/22/2013 |
| MRI of right chest | 03/22/2013 |
| Progress note | 03/28/2013 |
| Progress note | 04/04/2013 |
| Progress note | 04/18/2013 |
| Progress note | 04/25/2013 |
| A letter regarding adverse determination | 05/10/2013 |
| A letter regarding reconsideration adverse determination | 05/20/2013 |
| A request for an IRO for the denied services of "Right shoulder diagnostic arthroscopy, subacromial decompression, subcoracoid decompression and bursectomy possible release of short head biceps and treatment" | 06/20/2013 |

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a female who sustained injury on xx/xx/xx while lifting a heavy bag and experienced pain in her right shoulder. She was initially treated by physical therapy which made her condition worse after her last 2 PT sessions. She then had injection which gave her some improvement. She was evaluated and was recommended further physical therapy which was denied. then referred her to. She also had another injection that did not help. She was seen on 11/15/2012 was recommended work restrictions and MRI of the proximal arm. She then continued to follow up without much improvement in her pain symptoms. stated her pain was localized over the anterior axillary fold in the pectoralis. She then had MRI of the right humerus on 03/22/2013 that showed mild AC joint osteoarthritis. The MRI of the chest dated 03/22/2013 showed normal right pectoralis major muscle, right breast reconstruction, and mild AC joint osteoarthritis. She then had DD evaluation on 03/07/2013 and was given 8% WP IR. then continued to see her several times and on 04/25/2013 recommended right diagnostic arthroscopy, subacromial decompression, subcoracoid decompression and bursectomy possible release of short head biceps and treatment



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

The surgeon has recommended right shoulder diagnostic arthroscopy, subacromial and subcoracoid decompression, possible release of the short head of the biceps tendon as surgical intervention. After an extensive workup to rule out intraarticular glenohumeral pathology, a pectoralis tendon tear, and a cervical source, the subcoracoid region was finally identified as the source of pain. She had exquisite tenderness directly over the coracoid, pain with cross arm adduction, and substantial short term relief with 2 coracoid injections.

In applying the ODG guidelines to this particular case, I do not think that strict interpretation of “Acromioplasty” and “Ruptured Biceps Tendon” criteria are necessarily appropriate as these areas are not actually the source of pathology. Subcoracoid impingement is a very uncommon source of pathology in the shoulder and difficult to diagnose accurately, however I think that the surgeon has clearly identified the source of this patient’s pathology after an exhaustive workup. It should be noted that this particular problem does not fall conveniently into a criteria within ODG, and it is certainly a different disease process than SUBACROMIAL impingement or long head of the biceps pathology.

As such, I would conclude that this case should receive certification if the patient adequately meets criteria for diagnostic shoulder arthroscopy. Now about 1 year out from initial injury, I would agree that her imaging is inconclusive (for this particular disease process) and her pain and functional limitations continue despite an adequate course of conservative care (physical therapy, work restrictions, injections). In conclusion, I would disagree with the previous adverse determination. She meets criteria for diagnostic shoulder arthroscopy and SUBCORACOID decompression to address this uncommon source of shoulder pathology.



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ODG Criteria for 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)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

ODG Indications for Surgeryä -- 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 Surgeryä -- 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.



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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)