



# MedHealth Review, Inc.

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## Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:** 4/14/14

**IRO CASE #:**

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

The item in dispute is the concurrent medical necessity of a right arthroscopic SLAP debridement repair biceps tenodesis open repair.

### **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 disagrees with the previous adverse determination regarding the concurrent medical necessity of a right arthroscopic SLAP debridement repair biceps tenodesis open repair.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The female injured her right shoulder on xx/xx/xx. The injury mechanism included that the claimant was struck and diagnosed with a sprain/strain. A 10/01/2013 dated shoulder MRI revealed subacromial bursitis, anterior and posterior labral

tears, and a subcoracoid bursitis with an intrasynovial loose body. Medications and physical therapy (10/21/2013- 11/27/2013) provided minimal improvement. A corticosteroid injection provided one week of relief. On 1/28/14, there were ongoing complaints of right shoulder pain. Examination revealed diffuse tenderness, along with positive Apprehension and O'Brien's tests. On 03/04/2014, the AP's patient continued with right shoulder pain despite medication including Tylenol-codeine. Exam revealed diffuse tenderness and limited shoulder motion, positive apprehension and O'Brien tests, pain on anterior- posterior shift and a deep seated click with movement.

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

The combination of subjective and objective findings at the shoulder level correlate with the MRI. Despite a reasonable period of months of treatment including with restricted activities, physical therapy, medications and cortisone injection; the claimant has continued to be markedly symptomatic. The claimant has impingement and labral tears which correlate with the guideline indications for surgical intervention. The requests are considered medically reasonable and necessary at this time.

Reference: ODG Shoulder Chapter SLAP Lesion surgery Indications: 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. (Nam, 2003) (Pujol, 2006) (Wheless, 2007) 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. (Fedoriw, 2012)

Recent research: Study quality is not high, but it is consistent, and it continues to support this procedure for selected patients. Arthroscopic repair of SLAP lesions with extensive tears can achieve good outcomes. (Huang, 2013) Good to excellent results in Oxford shoulder scores were reported in 94% of patients, and no statistical correlation was found between the patient's age, female gender, and outcome scores. (Mok, 2012) Although the rehabilitation process may be

affected by a protracted period of pain, a long-term limitation of ROM after surgery is very unlikely. The results in this study are encouraging and the authors recommend anatomic restoration and repair of type II SLAP lesions.

(Boesmueller, 2012) Long-term outcomes after isolated labral repair for SLAP lesions are good and independent of age. Satisfaction was rated excellent/good for 88% of patients at 5 years. Postoperative stiffness was registered in 13.1% of the patients. (Schröder, 2012) While SLAP lesions of the shoulder that require surgical repair are relatively uncommon, there is a substantial increase in the number of arthroscopic SLAP repairs that is significantly more rapid than the rising rate of outpatient orthopedic surgical procedures. In addition, there is a significant increase in the age of patients who are being treated with arthroscopic SLAP repairs. (Onyekwelu, 2012) In 87% of cases, a good or excellent functional outcome can be anticipated after arthroscopic repair of type II SLAP lesions, but variables associated with a poor outcome include Workers' Compensation status. (Denard, 2012) 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.

**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)**