

True Decisions Inc.

An Independent Review Organization
2002 Guadalupe St, Ste A PMB 315
Austin, TX 78705
Phone: (512) 879-6332
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/11/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopic repair of rupture bicep tendon

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

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

MRI left upper extremity 09/11/13

Clinical notes 10/03/13

Clinical notes 10/17/13

Clinical notes 10/24/13

Clinical notes 11/14/13

Adverse determinations 10/22/13 and 11/15/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury to his left shoulder on xx/xx/xx. MRI of the left arm dated 09/11/13 revealed a complete rupture of the long head of the biceps tendon from its labral anchor with retraction of the tendon out of the bicipital groove. Mild muscular strain and edema were noted around the biceps muscle. Moderate atrophy was also noted at the teres minor. Clinical note dated 10/03/13 indicated the patient stating he had been lifting cabinets when he felt a pop in the shoulder. The patient stated the injury occurred xx weeks prior to the office visit. Pain was located at the left shoulder and mid left humerus. The patient stated he had been on light duty since the injury and was utilizing the left arm for light activities. Upon exam weakness was noted with abduction, supination of the left arm, and generalized tenderness was noted throughout the left shoulder and mid left humerus. Obvious Popeye muscle was noted secondary to rupture tendon. The patient was also noted to have a positive SLAP test with negative apprehension. Weakness was also noted with internal and external rotation of the left arm. The patient was recommended for an arm sling

at this time. Clinical note dated 10/17/13 indicated the patient being recommended for SLAP tear repair or biceps tenodesis. Clinical note dated 10/24/13 indicated the patient showing no swelling at the right shoulder. Pain was elicited with external rotation against resistance at the left shoulder and during O'Brien testing of the left shoulder. Clinical note dated 11/14/13 indicated the patient being recommended for surgical intervention. Utilization review dated 10/22/13 resulted in denial for surgical request as no clear evidence of a SLAP tear or description of his job was indicated in the clinical notes. No documentation was submitted confirming completion of conservative treatment. Utilization review dated 11/15/13 resulted in denial for a surgical repair of the left shoulder as the clinical symptoms including full thickness tear of the biceps was not recommended by guidelines.

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

Clinical documentation submitted for review notes the patient complaining of left shoulder pain at the shoulder and mid humerus. Biceps tendon repair would be indicated provided that the patient meets specific criteria, including the repair taking place within xx to xx weeks of the initial injury/diagnosis. Given the timeframe involved whereas the date of injury was in xx/xxxx this request is not indicated as no likely benefit will result from surgical intervention. As such, it is the recommendation of this reviewer that the request for an arthroscopic repair of the ruptured biceps tendon is not recommended as medically necessary.

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)