

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Oct/20/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** repair of bicep tendon

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Orthopedic Surgery

**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.** It is this reviewer's opinion that medical necessity for the requested repair of bicep tendon is not established and prior denials are upheld.

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury on xx/xx/xx to the neck and low back. The patient also described weakness in the left upper extremity at the elbow on flexion. The patient had been followed since 2012. The patient had been seen for physical therapy starting in 2010 with physical therapy notes continuing through February of 2013. The patient's medications had included the use of Temazepam, Tramadol, and Norco for pain. The patient was felt to have required a latissimus dorsi repair in the left upper extremity under CPT code 24341. MRI studies of the left shoulder completed on 08/23/11 were performed to evaluate for a biceps tendon rupture. This study identified intrasubstance partial thickness tearing of the distal supraspinatus superimposed over tendinosis. There was fraying of the labrum consistent with a type 1 SLAP lesion. There was intermediate soft tissue fullness at the long head of the biceps tendon with the long head of the biceps tendon not fully identified in the occipital groove which is compatible with a full thickness disruption. The expected location of the intraarticular portion of the long head of the long biceps tendon most likely represented the intraarticular long head biceps tendon. The report on 04/24/14 indicated that the requested latissimus dorsi repair was denied inappropriately by IRO. The patient was reported to have weakness at the left shoulder that was initially attributed to other injuries; however, in discussion with other orthopedic surgeons, it was felt that there had been a disruption of the latissimus dorsi tendon.

The patient's evaluation from 07/30/14 noted weakness on shoulder abduction with demonstration of a retraction of the skin over the latissimus dorsi origin to the left. The patient was again recommended for repair of this rupture.

The requested repair of the latissimus dorsi origin in the left upper extremity was denied by utilization review as it was unclear whether the procedure would significantly enhance the patient's functional capacity. It was unclear what prior conservative treatment had been attempted for this issue.

The request was again denied by utilization review on 09/11/14 as there was no imaging noting a tear of the latissimus dorsi. There was also no documentation regarding recent physical examination findings showing motion deficits due to a dysfunction at the latissimus dorsi.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been continually recommended for a latissimus dorsi repair for an extended period of time following the injury in question. The most recent evaluation did note some loss of left shoulder abduction with reproduction of skin retraction at the latissimus dorsi origin to the left. There is no imaging available for review identifying the extent of disruption at the latissimus dorsi tendon. The patient's abduction was not substantially restricted based on the most recent physical examination findings. At this point in time, it is unclear what reasonable functional improvement would be obtained with surgical repair of the latissimus dorsi. It is noted the patient has had prior physical therapy to address this issue; however, there is no documentation regarding any other recent attempts at rehabilitation. Given the chronicity of the injury and the absence of any indication that the patient has significant physical requirements that would reasonably support the requested repair, it is this reviewer's opinion that medical necessity for the requested repair of bicep tendon is not established and prior denials are upheld.

**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 KNOWLEDGBASE

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)