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Notice of Independent Review Decision

December 17, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
1 Left Shoulder with Superior Labrum Anterior-Posterior Repair

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is a Board Certified Orthopaedic Surgeon with over 42 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

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

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who underwent open reduction internal fixation on the left 5th metacarpal on 7/10/13. She underwent another surgery on 4/18/14 for extensor tenolysis, capsulotomy of the left 5th metacarpal. She also reported left shoulder and elbow pain.

09/23/2013: MRI Left Shoulder. **Impression:** SLAPP III Type tear.

10/25/2013: Progress Note. **PE:** PE of the elbow shows good motions. It appears to be subtle full flexion and extension. No varus valgus instability, but she is tender over the flexor rod attachment. Examination of the shoulder shows tenderness over the supraspinatus portion of the cuff. Crank test and supraspinatus isolation is painful. She has full passive motion.

11/26/2013: Progress Notes. PE: ROM of the fifth MCP is 0 to 60, maybe can be stretched to 70 somewhat limited. She has tenderness anterolaterally of the shoulder. Supraspinatus isolation is painful. She states the injection over left elbow gave her pain relief on her last visit. She has some tenderness over medial side but no instability. Recommendations: PT for shoulder and elbow.

12/17/2013: Initial Visit. MRI of the left shoulder shows that she did suffer a small SLAP tear type III of the labrum. She also strained the elbow. MRI shoulder was negative, most likely just muscle strain. No ligament damage of fracture. PE: Patient can flex when she makes a fist only to 40 at the MCP if she gets the PIP and DIP into full flexion. If the PIP and DIP straight, and only flex the MCP, then she is able to flex to 60 as her extrinsic extensors are tight. The wrist has good ROM. Minimal tenderness over the scapholunate, negative Watson maneuver. Elbow is tender over the medial and lateral epicondyles. The elbow is stable. Smooth arc of motion no crepitus. Shoulder impingement of the labrum positive with pain. External rotation is tender and painful.

01/08/2014: Progress Notes. **PE:** PE shows still tenderness over the shoulder. Supraspinatus isolation is painful as well as crank test. Examination of the hand shows fracture has healed most of all at the MCP joint of the fifth, but she lacks about 40 degrees to 50 degrees of flexion. **Medications:** no list on the chart.

01/21/2014: Progress Notes. **PE:** On PE, still a little bit of pain at the medial epicondyle where she pulled her flexor pronator attachment. She can extend the elbow and flex the elbow better, little bit of pain with resisted flexion and pronation localized to the epicondyle at the hand. She is still limited to about 40 to 60 degrees of MCP flexion to the small finger, but 80 degrees to the ring, 90 and 90 degrees to the long and index. Extensor lag still about 10 to 15 degrees.

02/19/2014: Progress Notes. **PE:** PE shows good motion of the shoulder. She is still tender over the supraspinatus portion of the cuff. She still has little tenderness over the fracture site, but healed. She has contracture of the MCP joint, which is planning on releasing. She also has tenderness over the medial aspect of the elbow and previous injection had helped her. Recommended getting an MRI of the elbow to rule out any significant ligament pathology.

04/11/2014: Progress Note. **HPI**: Patient reported that her symptoms have worsened over the last 10 months. She feels the symptoms have been related to work injury on xx/xx/xx. Symptoms are localized in her hand. **Medications:** Actos Oral 30mg, Calcium 600mg, Iron Oral, Naprosyn Oral 500mg, Synthroid 175mg.

04/29/2014: Quick Note. Pt presents with c/o pain, swelling, joint stiffness and loss of functional use of the affected LUE, specifically the left hand. **Assessment:** Pt noted to be c/o left shoulder pain and left elbow pain. She reports her elbow pain has been ignored. **Plan:** Ordered Occupational therapy evaluation. Therapeutic exercises.

05/06/2014: Required Medical Examination. **Medications:** Victoza, Synthroid and hydrocodone. **Inspection:** The shoulder levels are equal with a normal thoracic curve and chest cage without scapular winging or muscle spasm. There is no deformity or atrophy in the upper extremities which are symmetric except for a bony prominence on the left 5th metacarpal bone. Left shoulder type 3 slap is not a function of the xx/xx/xx work related injury event. The mechanism of injury is inconsistent with causation of the Type 3 SLAP tear. While the reportage of the MOI varies, no description is consistent with causation of a SLAP tear which usually occur due to repetitive overhead motion as a pitcher experiences or a significant compression force to the shoulder usually the result of a fall on an outstretched hand.
I do not agree with this determination. Left elbow medial epicondylitis is not present on the MRI. Therefore, the xx/xx/xx compensable injury cannot include left medial epicondylitis, Left shoulder TYPE 3 SLAP tear cannot be causally related to the xx/xx/xx compensable injury as explained herein. The Designated Doctor did not review the medical records related to the chronology of symptoms and complaints.

05/29/2014: Progress Note. **PE:** Pt has painful Yeargason's and Speed's test for her shoulder. She is under, again, treatment for the shoulder portion of the injury.

07/24/2014: Progress Note. **PE:** PE shows tenderness over the supraspinatus portion of her cuff. She has limited flexion due to pain. Crank test is painful. Examination of the elbow shows she still has tenderness over the medial epicondyle but good motion. There is no instability of the shoulder. Recommendations: Plan arthroscopy, superior labrum anterior and posterior repair and Tenex medial epicondyle debridement.

10/15/2014: History and physical. **HPI:** Follow up. Stated that she won the hearing and her left shoulder is covered as well as her elbow. She wants to proceed with surgery on her left shoulder as soon as possible. Records have diagnosed her with a superior labral tear. **PE:** PE of the shoulder shows that she has good mobility of the shoulder, but overt pain with crank test. Supraspinatus isolation is painful as well. She has fairly good strength. Examination of the elbow shows good motion. She is tender over the medial aspect and anteromedial aspect. Previous MRI of the elbow had not shown any abnormality. Recommendations: Going to plan diagnostic arthroscopy with superior labrum anterior-posterior repair of her shoulder in roughly 3-4 weeks.

11/03/2014: Progress note. **PE:** Examination shows tenderness over the shoulder. Supraspinatus isolation and crank test are both painful. External rotation and abduction is slightly restricted. Examination of the elbow shows tenderness over the medical epicondylar attachment. No instability of the elbow noted, just tenderness at the flexor wad attachment. Recommend PT program with her elbow. PT is unlikely to help her shoulder. Injected shoulder combination of lidocaine, Marcaine and decadron. Recommendations: We will get pt into a pt program with her elbow. Also, will resume therapy on her hand.

11/10/2014: Progress note. **PE:** Tenderness over the shoulder. Supraspinatus isolation is still painful. Crank test is painful. She lacks a little bit of full external rotation due to pain. The elbow shows tenderness over the medial epicondylar attachment. There does not appear to be significant edema today but noted tenderness. Recommendations: I will get her back in therapy for her elbow and schedule her surgery for her shoulder and get her back for follow up for her hand treatment.

10/28/2014: UR. Rationale for denial: The patient is a female who reported an injury on xx/xx/xx. On 10/15/2014, she reported left shoulder and elbow pain. The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The mechanism of injury was not provided in the medical records. The Guidelines do not indicate that surgery is needed for type 1 and 3 lesions and therefore, the requested procedure would not be medically necessary. In addition, there is no documentation showing that the patient had undergone 3 months of conservative treatment with NSAIDs and intervention. The requested is not supported by the Guideline recommendations as the patient does not meet the criteria listed in the Guidelines. As such, the request is non-certified.

11/24/2014: UR. Rationale for denial: The patient is a female who reported an injury on xx/xx/xx. The mechanism of injury reportedly occurred as the patient was driving and twisted her arm, breaking her hand twisting her elbow and shoulder. Her diagnoses include closed fracture of neck of metacarpal bones, medial epicondylitis, sprains and strains of unspecified site of elbow and forearm, disorders of bursa and tendons in the shoulder regions, and superior glenoid labrum lesion. The case was previously denied due to the guidelines not indicating that surgery is needed for type I and type III lesions. Therefore, the requested procedure would not be medically necessary. In addition, there was no documentation showing that the patient had undergone 3 months of conservative treatment with NSAIDs and PT directed towards her shoulder symptoms to indicate the need for surgical intervention. The request is not supported by guidelines recommendations and the patient does not meet the criteria listed in the guidelines. Medical necessity has not been established based on the provided documentation. In agreement with the original decision, the request is non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse determinations are upheld. Type III slap tears does not require surgery according to ODG Guidelines. Under the ODG Guidelines for surgery you must have had 3 months of conservative treatment, (NSAIDs, Physical Therapy). Therefore, the request for 1 Left Shoulder with Superior Labrum Anterior-Posterior Repair is non-certified.

ODG Guidelines:

Criteria for Surgery for SLAP lesions:
- After 3 months of conservative treatment (NSAIDs, PT)

- Type II lesions (fraying and degeneration of the superior labrum, normal biceps, no detachment)
- Type IV lesions (more than 50% of the tendon is involved, vertical tear, bucket-handle tear of the superior labrum, which extends into biceps, intrasubstance tear)
- Generally, type I and type III lesions do not need any treatment or are debrided
- History and physical examinations and imaging indicate pathology
- Definitive diagnosis of SLAP lesions is diagnostic arthroscopy
- Age under 50 (otherwise consider Biceps tenodesis).

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)**