

**IRO NOTICE OF DECISION – WC**

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**DATE OF REVIEW:** 04-06-07

**IRO CASE #:**

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

Denial of preauthorization approval for a left shoulder arthroscopy with superior labral anterior posterior lesion repair and biceps tenodesis

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

Certified by the American Board of Orthopaedic Surgery  
General Certificate in Orthopaedic 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 or not medical necessity exists for each of the health care services in dispute.

Injury Date	Pre-Authorization #	Review Type	ICD-9 DSMV	HCPCS/NDC	Upheld Overturn
		Prospective	8407	29807	Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Notices of Preauthorization Denial and Rationale (02-19-07 and 02-27-07)  
MRI of the right shoulder arthrogram (02-06-07)  
X-Ray views of the left shoulder (02-06-07)  
Physician Medical Notes and Work Status Reports (01-29-07 to 02-27-07)  
Medical History Questionnaire (01-29-07)  
Physician Determination Report (03-31-07)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker who slipped and fell landing on her left side hurting her shoulder. She received conservative treatment and eventually underwent a rotator cuff repair and subacromial decompression to her left shoulder on 11-15-06. Post-operatively she was on CPM machine, which broke, came apart and her arm came down hard without any control from the machine and had severe pain. Her treating physician's examination on 01-29-07 revealed decreased shoulder motion and weakness. The physician suspected possible re-tear of rotator cuff as result of the incident with CPM machine. X-ray views of the left shoulder on 02-06-07 showed no evidence of full thickness rotator cuff tear. An MRI of left shoulder arthrogram was also done on same day. The treating physician recommended left shoulder arthroscopy superior labral anterior posterior lesion repair and biceps tenodesis.

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

An MRI Left Shoulder Arthrogram done on 02-06-07 was reported as showing "fraying and/or a SLAP lesion in the left shoulder with a surgically repaired rotator cuff without a detectable recurrent tear". On the basis of this diagnosis, the physician recommended an arthroscopic SLAP repair.

Superior labral anterior and posterior lesions are usually caused by injuries. There are four SLAP classification {*Orthopaedic Knowledge Update* Vol. 8(2005)} often are associated with shoulder injuries, and produce overlapping non-specific symptoms. Treatment initially with Type 1 lesions is non-operative (NSAID, physical therapy) and perhaps one cortisone injection. Surgical intervention is usually reserved for a patient who does not adequately respond to a usual 6-week trial program.

According to the MRI, the patient may have a type 1 SLAP lesion and probably should have been treated with usual non-operative program. Therefore, I agree that this patient should have initially been treated with such a non-operative program and would deny arthroscopic surgery.

**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)