

RYCO MedReview

Notice of Independent Review Decision

DATE OF REVIEW: 09/28/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder arthroscopy, mini arthrotomy, and labral repair with acromioplasty

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

Board Certified in 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 or not medical necessity exists for each of the health care services in dispute.

Left shoulder arthroscopy, mini arthrotomy, and labral repair with acromioplasty - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRIs of the left shoulder interpreted by M.D. dated 11/18/05 and 10/27/06

A Required Medical Evaluation (RME) with M.D. dated 12/19/06
A supplemental report from Dr. dated 01/01/07
A CT arthrogram of the left shoulder interpreted by M.D. dated 06/20/07
Evaluations with M.D. dated 07/20/07 and 07/25/07
An evaluation with M.D. dated 07/20/07
A patient face sheet dated 07/28/07
A letter of non-certification, according to the ODG, from M.D. dated 08/02/07
A letter of non-certification, according to the ODG, from M.D. dated 08/22/07

PATIENT CLINICAL HISTORY [SUMMARY]:

An MRI of the left shoulder interpreted by Dr. on 11/18/05 revealed marked cuff tendonitis. An MRI of the left shoulder interpreted by Dr. on 10/27/06 revealed moderate tendonitis. On 12/19/06, Dr. recommended over-the-counter medications and a home exercise program. On 01/01/07, Dr. felt the patient had posttraumatic impingement syndrome in the shoulder with no rotator cuff tear and advised against surgery. A CT arthrogram of the left shoulder interpreted by Dr. on 06/20/07 revealed posterior humeral subluxation and a prominent sublabral foramen in the anterior labrum versus a short-segment tear. On 07/20/07, Dr. recommended left shoulder surgery. On 07/20/07, Dr. recommended a left knee surgery and right knee MRI. On 08/02/07, Dr. wrote a letter of non-certification for the left shoulder surgery. On 08/22/07, Dr. also wrote a letter of non-certification for the left shoulder surgery.

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

There was not sufficient documentation of conservative care undertaken for three months continually. This is out of the ODG and recommended for acromioplasty. Secondly, the objective clinical findings are conflicting. I have not seen a thorough shoulder examination. The orthopedic surgeon that lends support for the non-necessity of surgery is Dr. when he did a complete examination and found that there were no impingent signs and little evidence for the need of surgery for the rotator cuff. The clinical findings have not been conclusive for rotator cuff pathology either on examination or diagnostic studies. Therefore, at this time, I would not recommend the left shoulder arthroscopy, mini arthrotomy, and labral repair with acromioplasty and this is consistent with the ODG Guidelines.

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)**