I-Decisions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 03/23/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Shoulder arthroscopy, fixation of shoulder, right shoulder subacromial decompression, labral repair, and manipulation under anesthesia.

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

M.D., 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)

Upon independent review the reviewer finds that the requested services 23130, remove shoulder bone, 29826 and 29807 shoulder arthroscopy, and 23700 fixation of shoulder are not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Adverse Determination Letters, 02/19/08 and 02/28/08
2. ODG Guidelines and Treatment Guidelines
3. 02/19/08
4. Preauthorization request, 02/13/08 and 03/04/08

5. Radiology, 06/26/07
6. consultation, 01/14/08
7. 11/02/07
8. 07/25/07 and 06/12/07
9. Behavioral Medicine Evaluation, 07/11/07
10. WC Status Report, 02/08/08
11. 02/08/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a female with an injury. She is reported to be a horticulturist who fell into a hole while watering plants, which caused injury to the neck, right shoulder, and shooting pain to the fingers. She was reviewed by a spine surgeon and she was complaining of right shoulder pain and marked guarding of the shoulder. A good shoulder examination is not present within the medical records, particularly not one by the treating and operating surgeon. Physical findings that are reported include diffuse hypersensitivity to palpation and range of motion testing. The treating surgeon was not able to obtain a proper evaluation. Attempted evaluation under local anesthetic has not been made. There is evidence within the record of a potential complex regional pain syndrome situation, in which surgery would not be advisable. EMG testing was reportedly said to be normal. She states that when she had the subacromial injection, the pain was actually worse. Physical therapy apparently has been variable, and the diagnosis is currently unclear.

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

While there are MRI scan findings of a grade 1 superior labrum anterior and posterior lesion and hypertrophic bony changes along with a type 2 acromion, the records are also replete with evidence suggesting a psychological overlay, and the most concerning, a complex regional pain syndrome. According to ODG Guidelines, particularly concerning acute and chronic shoulder surgery, criteria for rotator cuff repair or anterior acromioplasty with a diagnosis of partial thickness rotator cuff tear or acromial impingement, is that of conservative care for three to six months. In a case such as this where the corroborative physical examination is absent, and the physical therapy is intermittent and based on the records lacking cooperation, at least six months of time should pass before considering surgery. A great extent of these patients get better without any surgical intervention whatsoever. However, the reviewer recognizes that the time since injury is greater than six months, the correlation of the diagnosis of SLAP lesion to the patient's actual pain complaints has not been made. As the previous reviewer suggested, diagnostic anesthetic blocks, both intraarticular and subacromial, would be of benefit in this case to permit some security as to the diagnosis. It is for these reasons that this reviewer is unable to overturn the previous adverse determination.

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)