



**Notice of Independent Review Decision**

**IRO REVIEWER REPORT – WC (Non-Network)**

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**DATE OF REVIEW:** 03/31/10

**IRO CASE #:**

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

Arthroscopy, Shoulder, Surgical, Repair of SLAP  
Extensive Shoulder Debridement  
Tenodesis Long Bicep Tendon  
Arthroscopic Rotator Cuff Repair  
Repair of Ruptured Musculotendinous Cuff  
Decompression of the Subacromial Space

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

Licensed 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.

Arthroscopy, Shoulder, Surgical, Repair of SLAP - UPHELD  
Extensive Shoulder Debridement - UPHELD  
Tenodesis Long Bicep Tendon - UPHELD  
Arthroscopic Rotator Cuff Repair - UPHELD  
Repair of Ruptured Musculotendinous Cuff - UPHELD  
Decompression of the Subacromial Space - UPHELD

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- MRI Left Shoulder, M.D., 10/29/09
- Physical Therapy Daily Progress Note, P.T., 12/09/09, 12/11/09, 12/14/09
- Evaluation, II, M.D., 12/15/09, 01/05/10, 01/19/10, 02/16/10, 03/01/10
- EMG/NCV, M.D., 01/05/10
- Evaluation, M.D., 01/11/10
- Pre-Authorization Request, Dr., Undated
- Adverse Determination Letter, IMO, 02/15/10, 02/25/10
- MRI Left Shoulder, M.D., 03/03/10
- The ODG Guidelines were not provided by the carrier or the URA.

## **PATIENT CLINICAL HISTORY (SUMMARY):**

The patient complained of left shoulder pain with abduction and weakness. An MRI performed on 10/29/09 indicated mild rotator cuff tendinosis without tear, mild subacromial subdeltoid bursitis and mild acromioclavicular joint arthrosis. There was no labral tear. A second MRI performed on 03/03/10 showed a small subacromial spur with small subacromial subdeltoid bursitis. There was tendinosis of the supraspinatus, infraspinatus and subscapularis tendons without full-thickness rotator cuff tear. The patient had undergone some physical therapy, but it did not help and his doctor discontinued therapy. An EMG/NCV was performed which did not suggest any radiculopathy or neuropathy in the left upper extremity. He was maintained on Tramadol, Motrin and Effexor.

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

Yes. The rationale is that the patient does have impingement syndrome and has failed to respond to conservative treatment. The subacromial decompression is completely warranted, and at the time of surgical intervention should a SLAP tear be encountered, should pathology of the long head of the biceps be encountered that would require tenodesis, should a torn rotator cuff be encountered, any or all, should be addressed at that time. Therefore, it is appropriate to request those procedures at the time of surgery, as it is noted when doing surgery, the diagnosis is changed at least 30% of the time, and the doctor should be able to address issues as necessary. The patient does meet criteria for the arthroscopic subacromial decompression and the attendant procedures, if necessary, would be appropriate. The patient meets ODG criteria as he has positive physical examination findings, subjective complaints, and MRI scan findings supporting the impingement diagnosis.

## **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)**