



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax:
877-738-4395

Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 12/22/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthroscopic synovectomy, subacromial decompression, and debridement of the right shoulder

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.

Arthroscopic synovectomy, subacromial decompression, and debridement of the right shoulder - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Patient Demographic and Information Sheet dated 09/02/08

Evaluations with, M.D. dated 09/02/08, 10/21/08, 11/04/08, 11/18/08, 12/09/08, 02/10/09, 03/24/09, 06/30/09, 07/30/09, 09/17/09, 10/08/09, 10/22/09, and 10/30/09

An operative report from Dr. dated 10/29/08

A letter from, M.D. at dated 10/30/09

A preauthorization notice dated 10/30/09 from ESIS

Another preauthorization noted dated 11/09/09

A letter from, M.D. addressed to Ms. at dated 11/10/09

An undated Surgery Preauthorization Request from Sports Medicine & Orthopaedic Group

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 09/02/08, Dr. diagnosed the patient with a full thickness rotator cuff tear of the left shoulder and possible sympathetic or cervical radicular component. Lyrica was prescribed and an MRI was recommended. Dr. performed right shoulder arthroscopic glenohumeral extensive debridement, complete glenohumeral synovectomy, subacromial decompression and bursectomy, and a mini open rotator cuff repair on 10/29/08. On 11/18/08, Dr. refilled Lyrica and prescribed physical therapy. On 02/10/09, the patient was doing well and was expected to return to work within a few weeks. She was progressed to phase III. On 06/30/09, Dr. performed a subacromial injection in the right shoulder. The patient stated on 07/30/09 that the injection helped considerably and she had returned to her regular job. Dr. assigned the patient a 7% whole person impairment rating. He noted she might need another subacromial injection in the future. Dr. stated on 10/22/09 that he felt the six permanent sutures in her rotator cuff were causing crepitation and inflammation. On 10/30/09, Dr. provided a denial for the requested right shoulder surgery. On 11/09/09, Dr. provided another denial for the right shoulder surgery.

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

Many patients have subacromial pain status post rotator cuff repair. I have not seen any evidence in the peer review literature that this could be due to and/or has been positively identified with sutures involved with arthroscopic rotator cuff repair or open rotator cuff repair. Certainly, with the vast number of arthroscopic and mini open rotator cuff repairs performed, one would think that if this was a pain generator postoperatively, this would have been identified in the literature by now. Furthermore, there is no diagnostic evidence of any residual pathology in the shoulder to justify further surgery. It also does not appear the patient has received adequate postoperative physical therapy, as recommended by the ODG. Therefore, the requested arthroscopic synovectomy, subacromial decompression, and debridement of the right shoulder is not reasonable or necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE
- 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)