

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 1/6/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal left shoulder arthroscopy for debridement of the paralabral tear and cyst

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from University of Maryland School of Medicine and completed training in Orthopaedics at University Hospital at Case Western Reserve. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Orthopaedics since 7/11/2004 and currently resides in MO.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

Appeal left shoulder arthroscopy for debridement of the paralabral tear and cyst Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Notice of assignment of independent review organization by xxxxx dated 12/17/2009
2. Operative report by MD dated 1/8/2009
3. Operative summary by MD dated 1/8/2009
4. Progress note by MD dated 10/9/2008-11/11/2009 multiple dates
5. MRI report of the left shoulder with and without contrast by Dr MD dated 8/18/2009
6. MRI report of the left shoulder with and without contrast by Dr MD dated 11/14/2008
7. Facsimile cover sheet by dated 12/17/2009
8. Fax cover sheet by dated 12/17/2009
9. Notice to utilization review agent of assignment of independent review organization by dated 12/17/2009
10. Notice to xxxxxxx of case assignment by dated 12/17/2009
11. Fax cover sheet by dated 12/16/2009
12. Confirmation of receipt of a request for a review by an independent review organization (IRO) by dated 12/16/2009
13. Letter by MD dated 12/15/2009
14. Letter by MD dated 11/19/2009
15. Communication note by MD dated 11/18/2009
16. Progress note by MD dated 11/11/2009
17. Precertification request by author unknown dated 10/8/2009
18. Progress note by MD dated 10/5/2009
19. MRI report of the Left Shoulder W/out contrast by Dr MD dated 8/18/2009
20. Progress note by MD dated 7/28/2009
21. Progress note by MD dated 2/24/2009
22. Progress note by MD dated 1/27/2009
23. Progress note by MD dated 1/19/2009
24. Operative report by MD dated 1/8/2009
25. Progress note by MD dated 12/9/2008
26. Patient referral sheet by author illegible dated 11/21/2008
27. MRI report of the Left Shoulder w/out contrast by Dr MD dated 11/14/2008

28. The ODG Guidelines were not provided

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This injured employee is a xxxxx. His date of incidence was xx/xx/xx when he was moving a trailer. An MRI on 11/08, specifically regarding his labrum demonstrated anterior and posterior glenoid labrum fraying. He underwent a sialoadenectomy (SAD), acromioplasty and Mumford procedure on 1/8/09. He participated in rehab post operatively. On 2/24/09 he received an injection. He continued to complain of shoulder pain after surgery. A repeat MRI on 8/18/09 demonstrated a small cyst adjacent to axillary pouch along posterior margin of glenoid. On 10/5 a clinic note documented subjective complaint of popping, exam with FROM, TTP anterior glenohumeral-joint (GH joint). On 11/11/09, the injured employee continued to complain of shoulder pain.

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

In this case, the occurrence of cysts with labral tears is well documented. However, this injured employee's case is not consistent with signs/symptoms of labral tear and/or instability.

The literature clearly documents spinoglenoid cysts with labral tears. This injured employee's MRI and cyst are not consistent with that pedology. There is no documentation of muscle atrophy. There is no documentation of instability which would be consistent with a labral tear requiring repair.

The injured employee has degenerative changes to his labrum as documented on the first MRI. Since his surgery, there has been no documentation of new injury and thus with a labrum with just degenerative changes, it is highly unlikely while completing rehabilitation he sustained a labral tear which would require repair. In addition, there was no mention in the original operative note regarding any labral pathology.

There is no documentation of clinical symptomatology of instability associated with a labral tear, no MRI documentation of labral tear requiring repair.

The additional pages provided were clinical notes, the latest exam note being 11/11/09. The note indicates continued pain with lifting. He is tender along GH joint. With shoulder adduction, there is crepitus and marked pain. There is subjective popping sensation; full abduction.

There is no mention of shoulder instability which usually accompanies labral pathology and no positive provocative tests for labral pathology.

Signs and symptoms of glenoid labrum tears include:

Pain, usually with overhead activities; Catching, locking, popping or grinding; Occasional night pain or pain with daily activities; a sense of instability in the shoulder; Decreased range of motion; Loss of strength.

Medical necessity was not established per ODG guidelines. Thus, the recommendation is to uphold the previous denial.

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

X 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

X PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

Orthop Clin North Am. 2003 Oct; 34(4): 521-8.

Ganglion cysts of the shoulder: technique of arthroscopic decompression and fixation of associated type II superior labral anterior to posterior lesions.

Westerheide KJ, Karzel RP.