Notice of Independent Review Decision

DATE OF REVIEW: 08/22/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient Right Shoulder Arthroscopic

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

Board Certified in Orthopaedic Surgery
Certified in Evaluation of Disability and Impairment Rating -
American Academy of Disability Evaluating Physicians

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.

Outpatient Right Shoulder Arthroscopic- OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Progress Note, D.O., 08/30/10, 11/10/10, 01/12/11
- Right Shoulder MRI, M.D., 09/17/10
- Progress Note, M.D., 01/20/11, 07/27/11
- Right Shoulder X-Rays, Dr. 01/25/11
- Right Scapula X-Rays, Dr, 01/28/11
- Correspondence, Dr. 03/18/11
- Utilization Review Referral, Dr. 05/03/11
- Pre-Authorization, Dr. Undated
- Denial Letter, 05/17/11, 07/11/11
- Examination, Unknown Provider, 06/10/11
- Pelvis X-Rays, Dr. 06/10/11
- Left Hip X-Rays, Dr. 06/10/11
- Physical Therapy Evaluation, Physical Therapy, 06/14/11
- Physical Therapy Update, P.T., 07/22/11

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient was injured when he got knocked down by a piece of equipment and caught himself on his outstretched right arm. He underwent right arthroscopic surgery on xx/xx/xx.

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

On 01/20/11, Dr. documented decreased range of motion in the shoulder, with pain reproduction and some weakness with resisted rotator cuff strength testing in all planes, particularly abduction and external rotation. There was tenderness over the AC joint with a positive impingement sign "that is quite notable". The claimant has documented conservative treatment. Subacromial and glenohumeral joint steroid injections have been provided, though the response has not been documented. Though the MRI is not specific, it does appear the claimant has a SLAP tear that was either unrecognized at the primary arthroscopy or recurred, and may require revision fixation or debridement.

I believe that the claimant meets medical necessity for revision arthroscopy, and would approve the request once the claimant is no longer using crutches for his unrelated pelvic fracture.

Conclusion based on medical judgment, clinical experience, and the following:
ODG: Surgery for SLAP lesions: Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. The advent of shoulder arthroscopy, as well as our improved understanding of shoulder anatomy and biomechanics, has led to the identification of previously undiagnosed

lesions involving the superior labrum and biceps tendon anchor. Although the history and physical examinations as well as improved imaging modalities (arthro-MRI, arthro-CT) are extremely important in understanding the pathology, the definitive diagnosis of superior labrum anterior to posterior (SLAP) lesions is accomplished through diagnostic arthroscopy. Treatment of these lesions is directed according to the type of SLAP lesion. Generally, type I and type III lesions did not need any treatment or are debrided, whereas type II and many type IV lesions are repaired.

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)**

☐ **AMA 5TH EDITION**