



Notice of Independent Review Decision

DATE OF REVIEW: 08/24/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bankart Procedure
Arthroscopy, Shoulder Distal Calviculectomy
Decompression of Subacromial Space

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.

Bankart Procedure – UPHELD

Arthroscopy – UPHELD
Shoulder Distal Claviculectomy – UPHELD
Decompression of Subacromial Space – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The patient had bilateral shoulder pain after a work related injury. X-rays showed osteophyte formation and acromioclavicular joint arthritic changes in both shoulders. He was initially treated with Naprelan 500 mg. Physical therapy was initiated. A left shoulder MRI showed mild to moderate supraspinatus tendinosis, particularly along the undersurface at the critical zone anteriorly, without evidence of a high grade partial or full thickness tear. There was moderate AC joint degeneration and edematous change in the subacromial subdeltoid bursa. Findings were highly compatible with a posterior labral tear with moderate sized paralabral cyst arising from the posterior inferior glenolabral junction, extending medially. Left shoulder surgery was recommended.

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

The ODG Guidelines for subacromial decompression indicate three months continuous or six months intermittent functional restoration aimed at gaining full range of motion with stretching and strengthening to balance the musculature. Such documentation is not noted in the medical records. The distal claviculectomy at this time is not supported as medically necessary as the subjective complaints and objective findings do not support the acromioclavicular joint as a pain generator, and the medical records did not document an injection of the acromioclavicular. For labral repair, ODG recommends type 2 and type 4 labral tears as being recommended for treatment. At this time one cannot determine the exact nature of this labral tear from the MRI scan provided for review. Therefore, I recommended non-certification of the requested procedure.

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 GUIDES 5TH EDITION