

SENT VIA EMAIL OR FAX ON
Feb/16/2012

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

Feb/16/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopic Left Shoulder Subacromial Decompression with Mirmford Procedures;
Arthroscopic Left Shoulder Examination Under Anesthesia; Arthroscopic Left Shoulder
Debridement; Possible Left Shoulder Rotator Cuff Repair

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Pre-authorization adverse determination 01/12/12

Pre-authorization reconsideration adverse determination 01/25/12

Pre-authorization request

Pre-authorization adverse determination 01/13/12

General orthopedic clinic notes Dr. 06/20/11-01/04/12

Plain radiographs left shoulder 06/20/11

Physical therapy notes 07/05/11-08/04/11

AR-CMI independent review organization summary 02/07/12

Employee's first report of injury or illness, request for medical care, authorization for release
of medical records report, and modified job offers

Notice of disputed issues and refusal to pay benefits 05/02/11

Emergency department records 04/23/11 and 04/25/11

MRI left shoulder 04/25/11

Office notes Dr. 04/28/11-06/22/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female whose date of injury is xx/xx/xx. Records indicate she was moving merchandise on a top shelf and hurt her left shoulder. Claimant was treated conservatively with medications and physical therapy. She was placed on work duty restrictions. MRI of the left shoulder performed 04/25/11 revealed spurring of the inferior aspect of the acromion with impingement on the superior aspect of the rotator cuff; probable SLAP in the posterosuperior labrum. Physical therapy progress note dated 08/04/11 indicated the claimant had completed 11 therapy visits and reports her shoulder has improved overall, having less pain and improved mobility. The claimant was seen on 01/04/12 in follow-up of left shoulder. She states that despite getting more motion with therapy she continues to have pain upon use of her arm away from her body, lifting overhead or repetitive maneuvers. Treatment options were discussed and the claimant was to proceed with cervical intervention.

A prospective initial pre-authorization review was performed on 01/12/12 and determined the request for arthroscopic left shoulder subacromial decompression with Mumford procedures, arthroscopic left shoulder examination under anesthesia, arthroscopic left shoulder debridement, and possible left shoulder rotator cuff repair was non-certified as medically necessary. It was noted that office visit on 11/09/11 revealed the claimant was getting better with conservative care until recent weather change. There is full flexion of 180 degrees and no AC joint tenderness. MRI dated 04/25/11 revealed spurring off the inferior aspect of the acromion with impingement on the superior aspect of the rotator cuff. The posterior aspect of the superior labrum was not well identified and may represent a SLAP tear. There is abnormal signal in the supraspinatus and infraspinatus tendons consistent with tendinitis and partial tear but no full thickness tear was identified. The AC joint is not mentioned. Progress note from Dr. on 01/04/12 revealed complaints of pain with use of arm away from the body and overhead use. There is now tenderness in the AC joint along with findings of pain and weakness with the drop arm test. It was noted there have been no injections in either the subacromial space or AC joint to assist in confirming of diagnosis of impingement or symptomatic AC joint. With report of full forward flexion and no AC joint tenderness on 11/09/11 and no injections, the reviewer was unable to establish medical necessity for the requested surgical procedure. A reconsideration request was reviewed on 01/25/12 and adverse determination was rendered. It was noted that following physical therapy the claimant achieved 90% of motion and pain was better with 180 degrees of flexion documented. It was also noted that the claimant has never undergone injection. On 01/04/12 the claimant was reported the claimant has ongoing pain and recommended subacromial arthroscopic decompression. It was noted there was confirmation of no injection being tried, and surgical request was determined as not medically necessary and inconsistent with ODG.

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

Based on the clinical information provided, the proposed left shoulder arthroscopic decompression, examination under anesthesia, debridement and possible rotator cuff repair is not indicated as medically necessary. The claimant is noted to have sustained injury to left shoulder while moving merchandise from top shelf. MRI performed 2 days after injury revealed spurring off inferior aspect of acromion with impingement on superior aspect of rotator cuff with probable SLAP lesion in posterosuperior labrum. Records indicate the claimant was treated conservatively with physical therapy and reported significant improvement in range of motion. She reported continued pain in shoulder despite improvement with therapy. On examination it appears the claimant had full range of motion of left shoulder. There was positive cross body adduction test, and positive impingement signs. Pain and weakness was also noted on drop arm test. Per ODG guidelines, there should be evidence of painful arc of motion 90-130 degrees and night pain prior to pursuing surgical intervention. There should be failure of at least 3-6 months of conservative treatment including stretching and strengthening exercises. There should also be evidence of positive impingement sign with temporary relief of pain with anesthetic injection (diagnostic injection).

Records indicate there has been no attempt at injection of left shoulder. Given the current clinical data, medical necessity is not established for surgery at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

- ACOEM-AMERICA 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)