



Notice of Independent Review Decision

DATE OF REVIEW: 05/03/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

OP Right Shoulder Scope SAD/poss RCR & Debride v Labral Repair 298927, 29826, 29823

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.

OP Right Shoulder Scope SAD/poss RCR & Debride v Labral Repair 298927, 29826, 29823 – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Evaluation, M.D., 08/04/11, 12/01/11, 02/23/12, 03/08/12
- Designated Doctor Evaluation (DDE), M.D., 03/01/12
- Right Shoulder MRI, Imaging, 03/08/12
- Notification of Adverse Determination 03/13/12
- Correspondence, Dr. 03/22/12
- Notification of Reconsideration Determination, 04/10/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured on xx/xx/xx when he slipped on a wet, metal floor and fell onto this right shoulder while pulling on tongs. The patient continued with right shoulder pain. His initial diagnosis was closed fracture of proximal end of humerus. An MRI of the shoulder showed tendinosis of the right supraspinatus to infraspinatus tendons. There was a partial tear of the right infraspinatus. The claimant did attend physical therapy. The diagnoses after review of the MRI were proximal humerus fracture, closed; rotator cuff sprain/strain/tear; impingement syndrome; and SLAP tear. The claimant was maintained on Talwin NX 50 mg/0.5 mg one to two tablets every four to six hours. The treating doctor recommended surgery at that time.

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

As noted in a prior Peer Review, the medical records provided did not adequately describe the conservative treatment received addressing impingement syndrome and the medical records fail to document physical examination finding supporting impingement syndrome as being present. Dr. noted on 03/22/12 that the greater tuberosity fracture had healed, but the patient was now suffering from traumatic impingement syndrome/bursitis, a partial rotator cuff tear, and labral tears, and noted now that the fracture has healed, the other injuries have become problematic. Dr noted the patient had completed appropriate non-operative treatment, including physical therapy and activity modification and was still having consistent and significant symptoms. At this time, Dr. did not document symptoms that would support impingement syndrome as a diagnosis and did not document physical examination findings that would support impingement syndrome as a diagnosis per the Official Disability Guidelines, and there was not adequate documentation of the functional restoration received to address impingement syndrome. Therefore, I recommend non-certification of the requested arthroscopic subacromial decompression, possible rotator cuff repair, debridement, and labral repair.

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

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE
IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES**