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Notice of Independent Review Decision

DATE OF REVIEW: 10/3/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of left shoulder arthroscopy with SAD and SLAP repair.

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

The reviewer is a Medical Doctor who is board certified in orthopaedic 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)

The reviewer agrees with the previous adverse determination regarding the medical necessity of left shoulder arthroscopy with SAD and SLAP repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source):

Records reviewed:

Progress Notes- 7/29/2013, 9/12/2013

Manual Muscle Strength Exam- Shoulder- 7/29/2013

Ultrasound Report- 3/2/2012

Records reviewed
Review letter - 8/8/2013, 8/23/2013, 8/27/2013
Pre Authorization Letter- 8/8/2013
Appeal Letter- 8/27/2013
Pre Certification Request- 8/5/2013
Reconsideration Letter- 8/5/2013
Electrodiagnostic Evaluation- 3/5/2012
X-Ray Shoulder- 10/18/2011
Left shoulder arthrogram- 6/8/2010
Operative report- 3/4/2009, 8/3/2010
Left shoulder arthroscopy- images- 3/4/2009, 8/3/2012
Medicine and Rehabilitation Re-Evaluation- 8/16/2010, 9/15/2010, 11/9/2010
MRI Left shoulder- 12/2/2011
Practice Associates- Initial Evaluation- 2/3/2012
Letter -(URA)- 6/28/2011

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was noted to have been injured while working. AP records discuss the patient's persistent burning left shoulder pain. There was a prior history of left shoulder arthroscopic surgery x 2, with SLAP and cuff repairs. Exam findings as of 9/12/13 revealed a 10 cm. lipoma and a prior surgical scar, tenderness and positive impingement signs. A 3/5/12 dated electrical study discussed multi-level acute and chronic cervical radiculopathy. A 12/2/11 dated left shoulder MRI with dye revealed an anchor from SLAP repair with possible reinjury/impingement. Prior post-op. treatments had included medications, PT and a cortisone injection. Denial letters discuss the history of cervical radiculopathy being a plausible symptom generator, along with the lack of recent comprehensive non-operative treatments.

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

Opinion: Denial(s) upheld

Rationale: Without a recent work-up (regarding plausible ongoing left-sided cervical radiculopathy) and without evidence of a recent and comprehensive non-operative treatment trial and failure for the left shoulder; applicable ODG criteria have not been met.

Reference: ODG Shoulder Chapter Indications for SurgeryTM -- Acromioplasty: Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.) **1. Conservative Care:** Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. **PLUS 2. Subjective Clinical Findings:** Pain with active arc motion 90 to 130 degrees. AND Pain at night. **PLUS 3. Objective Clinical Findings:** Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). **PLUS 4.**

Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement. ([Washington, 2002](#)) **Surgery for Impingement Syndrome**-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. ([Nam, 2003](#)) ([Pujol, 2006](#)) ([Wheeless, 2007](#)) Shoulder surgery for SLAP tears may not be successful for many patients. For example, of pitchers who failed physical rehabilitation and then went on to surgery just 7% were able to play as well as they had before, but for pitchers who just underwent physical rehabilitation, 22% were able to play as well as they previously had. ([Fedoriw, 2012](#))

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)