



Notice of Independent Review Decision - WC

DATE OF REVIEW:

05/15/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EUA Arthroscopy Left Shoulder Debridement, SAD, Mumford, Rotator Cuff/SLAP Repair

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.

EUA Arthroscopy Left Shoulder Debridement, SAD, Mumford, Rotator Cuff/SLAP Repair – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Physical Therapy, 11/12/12, 11/15/12
- Left Shoulder MRI, 11/19/12
- General Orthopedic Clinic Note, 02/04/13, 03/04/13
- Left Shoulder X-Rays, 02/05/13
- Pre-Certification, 03/04/13
- Denial Letters, 03/14/13, 04/04/13
- Peer Reviewer Final Report, 03/13/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured on xx/xx/xx at work; while lifting and trying to pull down on a hose, he felt a sharp pain in his shoulder. Since then, he had pain in the shoulder, especially with any motion and was severe in nature at times. The patient had impingement symptoms, as well as AC joint symptoms. He was maintained on therapy and medications for conservative therapy. An MRI of the left shoulder showed articular surface tear of the distal supraspinatus tendon measuring 3 mm. His treating doctor requested an EUA arthroscopy of the left shoulder/debridement, SAD, Mumford, rotator cuff/SLAP repair.

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

The surgical requests for the evaluation under anesthesia with arthroscopy of the left shoulder, debridement, subacromial decompression, Mumford rotator cuff repair, and SLAP repair are not medically necessary. The Official Disability Guidelines indicate that for a rotator cuff partial thickness debridement/repair, there should be three months of continuous or six months of intermittent conservative treatment directed at regaining strength and range of motion, but the current medical records fail to document the claimant having completed an appropriate course of conservative treatment to support the rotator cuff debridement/repair for the partial thickness tear.

The SLAP repair is not medically indicated as the ODG notes the criteria for a SLAP repair to be recommended for a Type II or a Type IV SLAP lesion. The current records with the MRI provided did not document a lesion for which the ODG would recommend surgical intervention. Therefore, the SLAP repair is not medically necessary.

The ODG indicates that for subacromial decompression, there should be three months of continuous or six months of intermittent rehabilitation of the shoulder with a directed course at getting full range of motion by requiring both stretching and strengthening exercises to balance the musculature, which was not documented.

I recommend non-certification of the evaluation under anesthesia with arthroscopy of the left shoulder, debridement, subacromial decompression, Mumford rotator cuff repair, and SLAP repair as not medically necessary.

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

- DWC - DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**