CASEREVIEW

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August 25, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left Shoulder Arthroscopic Labral Repair, Posterior & Anterior

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

This physician is a Board Certified Orthopedic Surgeon with over 13 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
This claimant is a male who was injured on XX/XX/XXXX when he was opening up a x. He injured his left shoulder. He has no past surgical history.

On March 20, 2015, the claimant presented with left shoulder pain that was moderate in nature. On examination he had tenderness to palpation at the greater tuberosity. ROM was 0-90 degrees. He was unable to abduct beyond 90 degrees, weakness with internal and external rotation. No joint instability on provocative testing. Positive drop arm test. Assessment: Left rotator cuff tear and left shoulder pain. Plan: Physical Therapy evaluation, MRI left shoulder, and Injection to the left shoulder. He was taken off work.

On March 30, 2015, Procedure Note, Procedure: Ultrasound Guided Injection.

On March 31, 2015, MRI Left Shoulder, Impression: Posterior subluxation of the humeral head on glenoid. Anterior and posterior labral tears.

On April 7, 2015, the claimant presented reporting minimal improvement following 3 sessions of PT and that the injection did not help him at all. Plan: Continue off work and PT.

On April 21, 2015, the claimant presented reporting continued complaints of pain and instability after attending a total of 8 therapy sessions. Physical exam remains unchanged. Plan: Continue PT. Continue off work status until 4/25/15,

return to full duty on 4/26/15.

On June 2, 2015, the claimant presented with complaints of left shoulder pain and wanting an injection for the pain. Plan: Refer to.

On June 15, 2015, the claimant presented with moderate to severe pain. He described the pain as aching and dull and radiates into his neck and upper arm. He reported the discomfort interferes with sleep and is present at rest. He also described a giving away in the left shoulder and catching in the left shoulder. He has had NSAIDs. He reported the pain is aggravated by lifting the arm above the head and strenuous activity. The pain is alleviated by heat, immobilization, and analgesics. On examination there was tenderness to palpation posteriorly, no swelling or deformities present. There was pain with ROM. Muscle strength was 5/5 in all LUE muscles. There was no joint instability on provocative testing. Negative sulcus sign. No anterior subluxation. Posterior subluxation present. No multidirectional instability. Apprehension test positive. Relocation test positive. Speed's test positive. A/C joint compression test, cross chest adduction test, Neer, Hawkins, impingement test, Obrien test were all negative. Assessment: Shoulder pain, Shoulder sprain strain, superior glenoid labrum lesion, Rotator Cuff tear. Plan: Shoulder arthroscopy: The patient had a fairly significant labral tear it extends superior both posteriorly as well as anteriorly. He is having mechanical symptoms as well as symptoms of instability.

On June 30, 2015, the claimant presented who indicated an injection had been completed and that it did help. Plan: Agree with surgery recommendation. Remain full duty until surgery.

On July 2, 2015, UR. Rationale for Denial: The Guidelines require a three months of conservative treatment, and there is no documentation of three months of conservative care. The claimant has only had three sessions of physical therapy, and there is no documentation of a home exercise program. Additionally, there is no documentation on the MRI of a Type II or Type IV SLAP lesion. The request for left shoulder arthroscopic labral repair, posterior and anterior is not authorized.

On July 8, 2015, EMG Report, Impression: There is no evidence of cervical spine radiculopathy or neuropathy of the upper extremities.

On July 13, 2015, the claimant presented who indicated, in response to the surgical denial, that the claimant had received 10 session of PT plus intervening therapy sessions on his own. He also stated the MRI quite clearly indicates a posterior and anterior labral tear.

On August 3, 2015, UR. Rationale for Denial: The previous noncertification is supported. Additional records included electrodiagnostic testing and evaluation on July 13, 2015. Official Disability Guidelines indicates type II and IV SLAP lesions should be treated surgically. The MRI documented no involvement of the biceps tendon or labral anchor. The request for reconsideration of a left shoulder arthroscopic repair (posterior and anterior) is non-authorized.

On August 17, 2015, the claimant presented with continued pain. Due to the surgery denials, he was prescribed Mobic to help with the pain and was continued on full duty.

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

Repair of the anterior and posterior labrum is medically necessary for this claimant.

The claimant is currently dealing with pain and instability in the left shoulder following a work injury. He has posterior subluxation on examination. He has a positive apprehension test and a positive relocation test. All of these examination findings are consistent with shoulder instability. The patient's MRI demonstrates anterior and posterior labral tears, which correlate with the patient's complaints and physical findings. The humeral head is subluxed posteriorly, pointing towards an incompetent posterior labrum.

He has already completed a course of conservative care consisting of ten sessions of physical therapy and a cortisone injection. I do not expect the patient's condition to improve without surgical intervention. Therefore, the request for Left Shoulder Arthroscopic Labral Repair, Posterior & Anterior is found to be medically necessary.

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)**