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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/05/2015

IRO CASE #: 87428

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right shoulder arthroscopy with slap lesion repair vs proximal biceps tenotomy, with or without tenodesis, shoulder orthosis/abduction positioning/airplane design and cryo rental x 7 days

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Orthopedic Surgery

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

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that medical necessity for right shoulder arthroscopy with slap lesion repair vs proximal biceps tenotomy, with or without tenodesis, shoulder orthosis/abduction positioning/airplane design and cryo rental x 7 days at this time is not established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who was injured on xx/xx/xx while pushing and pulling heavy bags. The patient developed complaints of pain in the right lateral shoulder. The patient was initially treated with anti-inflammatories and referred for physical therapy. The patient attended physical therapy through 02/02/15. The patient reported worsening pain with physical therapy. Initial radiographs of the right shoulder from 11/17/14 were negative for evidence of fracture subluxation. MRI right shoulder on 11/25/14 noted no evidence of labral pathology. Some non-specific cyst formation was noted in the posterolateral humeral head. This did not appear to be a contrasted study. The patient was evaluated on 01/08/15 regarding persistent right shoulder pain despite anti-inflammatories and narcotics analgesics. Physical examination noted limited range of motion in the right shoulder with positive O'Brien and Speed signs. There was some weakness with rotation and flexion and abduction. The requested right shoulder arthroscopy with SLAP lesion repair versus proximal biceps tenotomy with post-operative DME was denied by utilization reviews on 01/12/15 and 01/19/15 as it was unclear to the extent of physical therapy and MRI found no evidence of pathology of the labrum or biceps tendon.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical documentation submitted for review would not support the proposed right shoulder arthroscopy for biceps tenodesis for biceps tenotomy with or without tenodesis versus SLAP lesion repair. The patient has had persistent complaints of right shoulder pain despite the use of medications. The patient described pain with physical therapy. Although the recent physical examination findings noted positive O'Brien and Speed signs indicative of labral pathology, the provided MRI was

negative for any notable tears within the labrum or pathology involving the biceps tendon. This was a non-contrasted study and no other imaging studies were available for review including MR arthrogram studies finding evidence for a symptomatic SLAP lesion or biceps pathology that would support surgical intervention. As the clinical documentation submitted for review does not address the concerns of the prior reviewer, it is the opinion of this reviewer that medical necessity for right shoulder arthroscopy with slap lesion repair vs proximal biceps tenotomy, with or without tenodesis, shoulder orthosis/abduction positioning/airplane design and cryo rental x 7 days at this time is not established and the prior denials are upheld.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)