

IRO America Inc.

An Independent Review Organization

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DATE OF REVIEW: 4/10/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder arthroscopy

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

American Board of Orthopedics

Orthopedic Surgeon

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Right shoulder x-rays,
- Office notes, Dr. 10/05/04, 10/20/04, 11/17/04
- Cervical spine x-rays, 10/20/04
- Designated/Required/Independent Medical Examiner Impairment/Functional Evaluations, Dr. 03/24/05
- Right shoulder MRI, 04/12/05

- Designated report, Dr. 06/28/05
- Report of medical evaluation, 06/28/05
- Office note, Dr. 11/14/05
- Peer review, Dr. 01/18/07
- Request for surgery, 01/18/07
- Notice of UR findings by Dr., 01/24/07
- Office notes, Dr. 02/20/07
- Review, 03/02/07
- Pre-authorization determination denial appeal form, 03/07/07
- Timecards Paid From 06/27/04 to 10/01/04
- Note to claimant from, Dr. office, 01/12/05
- Hand written notes from RN regarding scheduling MRI of the right shoulder, 03/31/05
- Hand written note, source unknown regarding the request for MRI, 04/01/05.
- Nursing progress notes, 04/05/05, 04/06/05
- Notes requesting designated Dr. Evaluation, 06/15/05, 10/17/05
- Physical therapy progress notes, 02/10/06, 02/13/06, 02/24/06, 03/01/06, 03/24/06, 04/11/06 and 04/28/06.
- Note from regarding wage calculations, 08/09/06
- Notes from, notification of change in indemnity benefit payment, 10/23/06.
- Illegible date and form.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a right hand dominant female who injured her right shoulder on. Reportedly, the claimant was seen in the emergency room following the injury where x-rays showed degenerative arthritic changes suggesting chronic acromiale humeral impingement without fracture or dislocation. Apparently the claimant was diagnosed with a right shoulder sprain. Dr. evaluated the claimant on 10/05/04 because of continued right shoulder pain. Examination was documented to show motion within normal limits and minimal pain terminally. Physical therapy, Celebrex and recommendation to avoid strenuous activity or lifting were recommended. On 10/20/04 the claimant was again seen with complaints of right side of neck, right shoulder and right arm pain. Cervical spine x-rays on 10/20/04 revealed straightened mid cervical lordotic curvature. Follow up with Dr. on 11/17/04 noted continuing shoulder pain and an MRI was requested.

The medical records lapsed until a designated doctor examination dated 03/24/05 by Dr. who recommended an MRI and orthopedic consultation. An MRI of the right shoulder performed on 04/12/05 revealed a possible partial thickness superior surface tear of the supraspinatus or tendinopathy and a possible anterior labral tear. The claimant had continued difficulty including pain, tenderness, decreased motion and difficulty with activities of daily living. Evaluation by Dr. on 06/28/05 determined that the claimant had not reached maximum medical improvement and recommended an arthrogram or arthroscopic examination. On 11/14/05 Dr. determined that the claimant had reached maximum medical improvement with 5 percent whole person impairment for the diagnosis of right shoulder contusion and partial tear.

The next available medical records in a Peer Review dated 01/18/07 that documented that an arthrogram was noted on 08/01/06 not to be very impressive and as of 12/19/06 the claimant was diagnosed with internal derangement of the shoulder. On 01/18/07 a surgical request for

authorization of a right shoulder arthroscopy, repair of rotator cuff tear, repair of the supraspinatus and glenoid labrum, debridement and acromioplasty was submitted.

On 02/20/07 the claimant was examined by Dr. and he documented that an arthrogram had not been completed. The remainder of the office note was not legible. On 03/07/07 the surgical request was not certified and an appeal of that decision was requested.

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

Based on all the information reviewed above, the Reviewer would agree with the prior peer review determinations in this case as set forth by the carrier. In short, the information outlined above simply does not substantiate the recommendation for arthroscopic care.

Specifically, the MR arthrogram reportedly performed in August 2006 is not available. It was reportedly unimpressive. The treating physician's notes did not confirm subjective complaints suggestive of partial thickness rotator cuff injury. There are really no recent physical findings which would include ODG guideline suggestions of weakness, absent abduction, atrophy, subacromial tenderness, positive impingement signs, and a positive diagnostic injection test. As such, the criteria on which such a decision could be based have simply not been documented in this case.

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
 - Official Disability Guidelines: TWC: Treatment in Workers' Comp 2006; Fourth Edition; Shoulder, pages 1383-1384
- 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)