



DATE OF REVIEW: 12/15/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Left shoulder diagnostic arthroscopy with capsular relief and shoulder repair as necessary followed by physical therapy and rehabilitation for three months.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board-certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients with shoulder injuries

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. TDI Referral
2. Office notes of, MD, 5/15/07 through 11/6/07
3. Office notes of, MD, 11/9/06 through 1/5/07
4. Office notes of, MD, 2/5/06 through 2/13/07
5. URA findings, 9/12/07 through 10/9/07
6. MD, peer review, 10/6/2007
7. ODG Guidelines from carrier, undated
8. Imaging, MRI left shoulder, 10/12/2006
9. Medical Associates, exam, 10/6/2006
10. Surgical Center, shoulder arthroscopy, 2/13/07
11. PT notes, 3/27/07
12. Diagnostics, Left Shoulder Arthrogram/MRI, 8/23/2007
13. MD, office notes, 8/1/07 through 11/7/07

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This xx-year-old male fell at work onto his outstretched left hand. He suffered a nondisplaced greater tuberosity fracture of the left shoulder. The date of injury was xx/xxx/xx. The nondisplaced fracture of the greater tuberosity of the left shoulder healed; however, the patient remained symptomatic. He was evaluated by Dr. , and an MRI scan revealed a superior labrum anterior and posterior (SLAP) lesion. On 02/13/07 an arthroscopic procedure was performed, and the SLAP lesion was repaired. The patient has remained symptomatic with pain and diminished range of motion. He has had physical therapy and a recent arthrogram with MRI scan followup. The requested preauthorization for diagnostic arthroscopy and capsular release shoulder repair as necessary followed by physical therapy and rehabilitation for three months has been previously denied.

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

The patient's range of motion has improved between 07/11/07 and 09/11/07. A recent MRI scan failed to reveal evidence of adhesive capsulitis. The rotator cuff was intact, and no diagnostic abnormalities that might benefit from arthroscopic surgery were present.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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, Shoulder Chapter, pages 1780 and 1790.
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)