

Parker Healthcare Management Organization, Inc.

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DATE OF REVIEW: JUNE 26, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed left shoulder arthroscopy, subacromial decompression, mini open rotator cuff repair

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

This case was reviewed by a licensed. The reviewer specializes in full time practice.

REVIEW OUTCOME

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

- Upheld (Agree)
 XX Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
			Prosp	1			xx/xx/xx		Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-17 pages

Respondent records- a total of 10 pages of records received to include but not limited to:
Letters, 6.8.07, 3.23.07; letter, 4.24.07

Requestor records- a total of 11 pages of records received to include but not limited to:
Notice of IRO; Notes, Dr., 2.9.07-5.4.07; MRI, LT Shoulder 2.13.07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained an on the job injury on xx/xx/xx. He injured his left shoulder/arm while unloading pipe from a trailer.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

1. ODG Guidelines criteria for diagnostic arthroscopies state that a shoulder arthroscopy should be performed when acute pain or functional limitation continues despite conservative care.
2. It has now been approximate 6 months since the date of onset of the injury and diagnosis of impingement.
3. The patient has a type II acromia.
4. The patient was injected with steroids and local anesthesia and had relief of pain. The pain recurred.
5. The patient has been treated appropriately with non-operative treatment.
6. The patient has tenderness in the subacromial shoulder.
7. Therefore, surgery to decompress the subacromial space is indicated.

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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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
- XX PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(NEER 1983. Impingement lesions; Clinical Orthopedics and related research; REID, D.C. 1992. Sports injury assessment and rehabilitation, page 536. New York, Churchill, Livingston.)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)