

# IRO Express Inc.

An Independent Review Organization

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**DATE OF REVIEW:** MAY 22, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Outpatient left shoulder arthroscopic subacromial decompression.

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

Board Certified 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**

Left shoulder x-ray, 03/08/05 and 03/27/06  
Office notes, Dr., 03/16/05, 03/30/05, 04/11/05, 04/10/06, 09/06/06, 09/20/06, 12/01/06, 01/17/07, 02/14/07 and 02/21/07  
Physical therapy notes, 03/22/05, 03/29/05 and 04/04/05  
Left shoulder MRI, 04/06/05  
Peer review and record review, Dr., 12/06/06  
Left shoulder arthrogram, 01/02/07  
Review, 02/12/07  
Letter from Dr., 03/05/07 and 04/19/07  
Orthopedic review, Dr., 03/12/07

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a male who fell out of his van. The left shoulder x-rays showed mild degenerative changes of the left acromioclavicular joint with the glenohumeral joint appearing intact. The claimant saw Dr. for complaints of left shoulder pain. The claimant noted no previous problems with his shoulder. Exam findings revealed no tenderness over the acromioclavicular joint. All range of motions were normal. The claimant completed a course of physical therapy and was seen by Dr. on 03/30/05 for improvement; however, the claimant still had pain with extremes of external rotation and abduction. Dr. recommended a left shoulder MRI which was performed on 04/06/05 and showed mild supraspinatus tendinosis without rotator cuff tear. There were acromioclavicular joint changes, mild subacromial bursitis and focal edema involving the posterior/superior humeral head representing degenerative change versus a remote Hill Sachs deformity.

On 04/11/05, Dr. released the claimant and he was to follow up as necessary. At that time, the claimant had good range of motion without significant pain. The left shoulder x-rays showed severe acromioclavicular sclerosis with inferior spurring. The claimant returned to Dr. for recurrence of left shoulder pain. Exam revealed significant pain on range of motion. An injection was performed. On 09/20/06, the claimant was doing much better. On 12/01/06, the claimant reported to Dr. short term relief with the injection. A MR arthrogram was recommended and performed on 01/02/07 which was negative. Another shoulder injection was performed by Dr. on 01/17/07. A peer review was performed on 02/12/07 and the surgery was denied due to the acromioclavicular joint not being assessed with an injection and the acromioclavicular joint was non tender.

On 02/14/07, Dr. documented that the claimant was scheduled for surgery but was denied by workers compensation due to no injection being performed. Dr. felt that the claimant's pain was subacromial and performed an injection. The 03/05/07 letter authored by Dr. documented no relief from the injection. On 03/12/07, Dr. performed a review and denied the requested surgery due to the MRI did not reflect a rotator cuff defect. On 04/19/07, Dr. authored a letter and acknowledged that the claimant had sclerosis but felt that it was not a significant source of his pain. Dr. felt that the claimant's current symptoms were directly related to the injury. Dr. requested an IME to determine the relatedness of the injury.

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

The claimant is a man who apparently injured the left shoulder. He underwent x-rays showing arthritic changes and an MRI documenting some rotator cuff tendonitis. He had improvement with conservative care and then over time developed progressive increased discomfort. He had re-do x-rays documenting progressive acromio-clavicular joint arthritis and was seen by Dr., who had previously evaluated him after the acute injury, and underwent an injection without improvement. He had an arthrogram of the left shoulder without evidence of a rotator cuff tear and a repeat injection without good long term improvement. In light of the claimant's ongoing pain and limitations in function and apparent failure of conservative care, it has been requested that he undergo a left shoulder arthroscopic subacromial decompression.

In light of the fact that the claimant has ongoing pain, limitations in function, lack of improvement with conservative care, and x-rays/MRI's documenting some rotator cuff tendonitis and acromio-clavicular joint arthritis, it is medically reasonable to proceed with the left shoulder arthroscopic subacromial decompression in an attempt to treat his pain and failure of improvement with his previous conservative care.

**IRO REVIEWER REPORT TEMPLATE -WC**

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**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**
  - 2007 Official Disability Guidelines, 12<sup>th</sup> edition, Integrated with Treatment Guidelines (ODG Treatment in Workers' Comp, 5<sup>th</sup> edition). Shoulder, Surgery for Impingement Syndrome
- 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)**
  - Orthopedic Knowledge Update, Shoulder and Elbow, Chapter 50, page 519-520