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IRO America, Inc.

IRO REVIEWER REPORT TEMPLATE -WC

DATE OF REVIEW: 11/11/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder infraspinatus and supraspinatus peritendon injection with fluoroscopy and MAC anesthesia

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

M.D., neurologist and fellowship-trained pain specialist, board certified in Neurology and Pain Medicine

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Determination for denial of requested services by dated 09/06/07 as well as determination on reconsideration with denial upheld by dated 09/25/07
2. Letter by Dr. dated 10/12/07 as well as letter of reconsideration by Dr. dated 09/12/07
3. Office notes from Dr. dated 08/15/07 as well as "additional data page" dated 08/31/07
4. No ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant sustained a work-related injury on xx/xx/xx. The claimant has had ongoing complaints of neck and back pain as well as left shoulder pain. Shoulder MRI scan reportedly showed evidence of tendinosis of the supraspinatus and infraspinatus tendons. The claimant has already undergone three steroid injections for the left shoulder, which have provided “greater than 50% relief.” Though prior reviewers did not apparently have the dates of these prior injections, a note from Dr. from 08/15/07 indicates that the left shoulder injections were done on 05/26/06, 08/30/06, and then on 03/06/07, with the last injection noting to have helped “at least 50%” to decrease pain. Also noted on this visit is the MRI scan findings from 04/25/06 showing tendinosis of the supraspinatus and infraspinatus tendons in the left shoulder. The claimant had been undergoing physical therapy also mentioned on this note from 08/15/07 in addition to taking medications including hydrocodone as well as Ultram and Soma, with previous trials with muscle relaxers including Norflex, Skelaxin, and Flexeril. Note from 08/31/07 indicates that the patient has “failed conservative therapy,” which has included the various analgesics including nonsteroidal anti-inflammatory medications as well as physical therapy. Since the claimant did have significant relief of greater than 50% with his previous injection, an updated injection was requested by the claimant and put in for authorization by his physician, Dr..

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

It is quite clear that this claimant has benefited from steroid injections to and around the left shoulder with the last injection having been done over half a year ago in early. The prior two injections were done over a year ago. As the claimant has tried additional treatment measures without success, the Reviewer’s medical assessment is that it would be medically reasonable and necessary to proceed with an updated steroid injection as requested. It appears that the claimant is also planning to see his orthopedic surgeon for an updated visit, Dr., but was hoping for symptomatic relief in the interim. It is certainly possible that with a similar or even better response to the steroid injection, especially if continued with appropriate exercises, etc., he may be able to avert any surgical procedures, etc. The Reviewer considered the ODG Guidelines in the determination of the case, but as discussed above, the Patient’s circumstances were such that the Reviewer determined it was necessary to diverge from the Guidelines.

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
- 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)