



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 10/01/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder arthroscopy with possible rotator cuff repair

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

Board Certified in Orthopedic Surgery

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.

Left shoulder arthroscopy with possible rotator cuff repair - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A patient information form dated 05/25/07
Evaluations with, M.D. dated 05/25/07 and 08/09/07
A DWC-73 form from Dr. dated 05/25/07

An MRI of the left shoulder interpreted by, M.D. dated 05/30/07
An EMG/NCV study interpreted by, D.O. dated 06/08/07
Preauthorization requests from Dr. dated 06/13/07 and 08/15/07
A letter of non-certification, according to the ODG, from, D.O. dated 06/19/07
An evaluation with an unknown therapist (the signature was illegible) dated 07/13/07
A letter of non-certification, according to the ODG, from, M.D. dated 08/22/07

PATIENT CLINICAL HISTORY

On 05/25/07, Dr. recommended an EMG/NCV study and an MRI of the shoulder. An MRI of the left shoulder interpreted by Dr. on 05/30/07 revealed severe tendinopathy/tendonitis, a subchondral cyst, and mild degenerative changes of the AC joint. An EMG/NCV study interpreted by Dr. on 06/08/07 was unremarkable. On 06/13/07 and 08/09/07, Dr. recommended left shoulder surgery. On 06/19/07, Dr. wrote a letter of non-certification for left shoulder surgery. On 07/13/07, the unknown therapist recommended physical therapy three times a week for four weeks. On 08/22/07, Dr. wrote a letter of non-certification for left shoulder surgery.

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

At this time, although there has been some conservative management performed, this is basically an impingement syndrome case. The patient appears to have undergone some occupational therapy; however, besides this, there is really not much else the patient has received. I do not see any documented evidence of a subacromial injection, which is part one of the clinical objective findings noted in the ODG and should be performed prior to proceeding with surgery. Also, according to the ODG, the MRI must show positive evidence of deficit in the rotator cuff, which was not seen on the patient's MRI study. Therefore, the requested left shoulder arthroscopy with possible rotator cuff repair is not reasonable or necessary as related to the original injury.

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 AND KNOWLEDGE BASE**
- 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)