

SENT VIA EMAIL OR FAX ON
Dec/08/2008

IRO Express Inc.

An Independent Review Organization

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DATE OF REVIEW:

Dec/08/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

left shoulder arthroscopy capsular release; manipulation under anesthesia; subacromial decompression

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

Doctor of Medicine (M.D.)?

Board Certified in Orthopaedic Surgery?

Fellowship Training in Upper Extremities

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

OD Guidelines

Denial Letters 11/11/08, 11/6/08, 10/27/08

Records from Medicine 8/19/08 thru 11/6/08

MRI's 6/5/08 and 7/31/08

Record from Specialists 11/3/08

Record from DOC 10/21/08

Records from Group 5/29/08 thru 10/16/08

Records from and PT 8/26/08 thru 11/3/08

PATIENT CLINICAL HISTORY SUMMARY

The injured employee suffers from left shoulder pain. MRI is inconclusive. The patient has 165 degrees of forward flexion and 25 degrees of active external rotation. She has cervical stenosis and left neuroforaminal stenosis. The records state that she had a shoulder injection; however, the actual injection and follow up was not provided.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

The requested procedure is not medically reasonable and necessary for this patient. The patient has adequate range of motion, and the arthroscopic release is not indicated. Conservative care for adhesive capsulitis and impingement syndrome has not been exhausted.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

- ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)