

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 05/04/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Shoulder arthroscopy, diagnostic, with or without synovial biopsy and rotator cuff tear repair.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., F.A.C.S., Board Certification, American Board of Orthopedic Surgery, with experience in the evaluation and treatment of patients suffering shoulder injuries

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

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

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
719.41	29805	NA	Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

- TDI case assignment forms
- Letters of denial dated 04/16/08 and 04/23/08
- Orthopedic examinations, 01/18/08, 02/22/08, and 04/11/08
- Orthopedic consultation, 09/20/07
- MRI scan, 08/31/07
- Review of medical records, 03/30/07

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This xx-year-old male suffered injuries to his left shoulder on xx/xx/xx. His complaints are principally pain. Current physical findings are not well documented. There is a past history of an MRI scan on 08/31/07, which suggested rotator cuff tendinosis and bicipital tendon tendinosis. There is an x-ray report suggestive of acromioclavicular arthropathy. There is no documented non-operative treatment. The history and physical examinations are inconsistent.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

The diagnosis appears to be one of rotator cuff impingement syndrome. The clinical significance of the rotator cuff tear near the insertion of the supraspinatus portion of the rotator cuff is not clear. There is no documentation of non-operative management. Much of the clinical information is a criticism of the current system of preauthorization review and independent review.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- ODG-Official Disability Guidelines & Treatment Guidelines, Shoulder Chapter, page 1641)
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)