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Notice of Independent Review Decision

DATE OF REVIEW: 5/28/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder rotator cuff repair, subacromial decompression, SLAP lesion repair
Marcaine with epinephrine for interoperative control of hemostasis, not as a
nerve block

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 rotator cuff repair, subacromial decompression,
SLAP lesion repair – Upheld
Marcaine with epinephrine for interoperative control of hemostasis,
not as a nerve block - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Subsequent Medical Report, D.C., 01/15/07
Initial Medical Report, Dr. 07/27/07
MRI Shoulder w/o Left, D.C., 01/10/08
MRI Left Shoulder w/contrast (Indirect MRI Arthrography), Dr., 02/20/08
Examination Evaluation, M.D., 03/26/08, 04/09/08
Pre-Authorization Request, Dr. 04/02/08, 04/17/08
Adverse Determination Letter, 04/07/08, 04/24/08
Surgery Orders, Dr. 04/22/08, 05/06/08
Notice of Assignment of Independent Review Organization, 05/08/08
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained an injury to her left shoulder. An MRI of the left shoulder was performed on 01/10/08, and another MRI was performed on 02/20/08. She has a previous history of two epidural steroid injections.

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

The procedure is not medically reasonable or necessary at this time, per ODG Shoulder, because the patient has not undergone sufficient preoperative evaluation for therapy. The patient has been treated essentially with passive therapy and has not attempted physical therapy. In addition, there has not been a positive impingement test; that is, injection of the subacromial space with local anesthetic and evaluating the range of motion and pain response thereafter. It has been shown that the results of surgery are fairly well predicted by the response of the patient to the subacromial decompression. In the event that the patient did not have a good response, then surgery would be unlikely to help.

Furthermore, the intra-articular injection is neither medically reasonable nor necessary. The intra-articular injection of Marcaine and epinephrine is a portion of the surgical procedure and should not be considered a medically separate procedure.

Since the claimant has not had adequate nonsurgical care, proceeding with surgery at this time is neither medically reasonable, nor necessary.

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)