

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 6, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthroscopy of the Left Shoulder and Distal Clavicle Resection

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

MD, Board Certified Orthopedic Surgeon

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.

The reviewer finds that arthroscopy of the Left Shoulder and Distal Clavicle Resection is medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 2/21/08, 3/10/08
ODG Guidelines and Treatment Guidelines
3/28/08, 3/14/08, 2/29/08, 1/9/08, 12/11/07, 2/12/08, 11/29/07
MRI Elbow, 7/30/07
MRI Shoulder, 7/30/07
MRI, Lumbar Spine, 7/30/07

7/24/07
X-Rays, 7/5/07, 8/21/07, 12/17/07
IRO Summary, 4/22/08
X-Ray Shoulder, 7/5/07, 8/21/07, 12/17/07
X-Ray Wrist, 7/5/07, 12/17/07
DC, 7/5/07
MD, 8/21/07, 9/11/07, 10/9/07, 11/13/07
1/31/08
IRO Decision Letter (for different item), 10/3/07
Employers First Report of Injury
Health, 7/5/07, 7/16/07, 7/17/07, 7/23/07, 7/24/07, 7/27/07, 8/6/07, 8/27/07, 9/10/07, 9/24/07,
10/8/07, 10/22/07, 10/24/07, 11/8/07, 11/26/07, 12/17/07, 1/7/08, 1/11/08, 1/14/08, 1/15/08,
1/16/08, 1/17/08, 1/21/08, 1/2/08, 1/23/08, 1/24/08, 1/25/08, 1/28/08, 1/29/08, 1/30/08, 2/1/08,
2/4/08, 2/5/08, 2/6/08, 2/7/08, 2/11/08, 3/4/08
Conductive garment prescription, 11/9/07
Custom orthotics, 1/29/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee was injured at work, resulting in bilateral shoulder pain. The patient has undergone extensive physical therapy over a period of greater than three months. The claimant has had injections of cortisone, which documented relief on a temporary basis but now has recurrence of pain and loss of function. The claimant had an MRI scan, which documented degenerative changes in the acromioclavicular joint, partial tears in the supraspinatus, and superior labral tears, as well. A note is made that there are actual similar changes in the contralateral shoulder.

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

The reason for the adverse determination being overturned is as follows. While it is true that the contralateral shoulder shows similar findings, and, in fact, the previous reviewers' comments of these being degenerative in nature may well have a foundation in reality, nevertheless, based upon the treatment plan and documented medical records, the patient has symptoms post injury, has had improvement temporarily with injections, has had the required ODG physical therapy management, and has the clinical findings compatible with an ongoing impingement. Indications, therefore, meet per ODG Guidelines for arthroscopic decompression. It is for this reason that the previous adverse determination has been overturned. The reviewer finds that arthroscopy of the Left Shoulder and Distal Clavicle Resection is medically 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)**