

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/12/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left shoulder arthroscopy with subacromial decompression

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines

Adverse Determination Letters, 6/16/09, 7/7/09

MD, 6/26/09, 6/8/09, 5/8/09, 11/21/08, 11/7/08, 9/26/08

6/12/09, 7/1/09

Precert Request, 6/8/09

MD, 6/5/09

MRI left shoulder, 9/5/08

MD, EMG/NCS, 3/31/09

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who was injured on xx/xx/xx. He has had physical therapy. He had an injection of cortisone with no relief. He had 12 cc of Xylocaine into the left shoulder with reports of ongoing left shoulder pain after this injection. His shoulder MRI scan reveals tendinitis and some downsloping of the acromion. He apparently has essentially full range of motion and normal strength. There is a 2-mm C6/C7 disc protrusion but no evidence of cervical abnormality or neurological/radiculopathy. The previous reviewer denied this as not meeting the ODG Guidelines.

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

Based upon the ODG Guidelines and Treatment Guidelines, this patient does not meet criteria, although he has had three to six months of conservative care, in fact, greater than this. He has not had a positive response to diagnostic injections based on the medical records provided. It is for this reason that the previous adverse determination cannot be overturned as the objective diagnostic testing, i.e., the MRI scan, along with the next intraarticular injections, both cortisone and Xylocaine, do not permit this reviewer to come to the conclusion that this patient meets the ODG Guidelines, which are statutorily mandated in the State of Texas. The reviewer finds that medical necessity does not exist for Left shoulder arthroscopy with subacromial decompression.

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)