

# Becket Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/08/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Right Shoulder Diagnostic Arthroscopy and any indicated procedures possible bursectomy

**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 and Treatment Guidelines

Adverse Determination Letters, 9/22/09, 9/14/09

Dr. 4/1/09, 4/8/09, 5/6/09, 6/5/09, 6/25/09, 7/27/09, 9/9/09, 10/21/09, 10/5/09

MRI Right Shoulder, 4/7/09

MD, 10/5/09

Center for Physical Medicine, 7/15/09

Work Recovery, 7/15/09, 6/23/09

### PATIENT CLINICAL HISTORY SUMMARY

This is a female who has pain in her right shoulder. She was lifting a heavy door when she heard a pop in her shoulder. She has had physical therapy and injections with no relief. Examination of the right shoulder shows full range of motion. There is noted positive impingement test and positive apprehension test, though no relocation test was utilized. The MRI scan report was normal. An arthrogram was recommended, however, this was not performed. The diagnosis was dictated as being impingement syndrome. The request is for shoulder arthroscopy, diagnostic, with bursectomy.

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

The diagnostic arthroscopy request does not conform to Official Disability Guidelines and Treatment Guidelines. The ODG requires MRI, ultrasound or arthrogram to show positive evidence of impingement. The MRI was normal. The provider in this case has not determined the cause of the patient's impingement according to the records. The reviewer finds that medical necessity does not exist for Right Shoulder Diagnostic Arthroscopy and

any indicated procedures possible bursectomy.

**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)