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IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 06/25/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder arthroscopy with subacromial decompression

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 arthroscopy with subacromial decompression - Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY

The Employer's First Report of Injury or Illness form on xx-xx-xx stated the patient was struck by falling merchandise and strained multiple body parts. Physical therapy was performed with the unknown therapist from 12/12/08 through 01/08/09 for a total of seven sessions. On 12/17/08, Dr. prescribed Darvocet-N, Flexeril, and Naproxen. An MRI of the left shoulder interpreted by Dr. on 01/19/09 revealed mild subscapularis and supraspinatus tendinopathy

with no evidence of a tear. On 02/23/09, Dr. recommended a subacromial Cortisone injection and it was performed on 02/27/09. Left shoulder surgery was recommended by Dr. on 03/13/09. On 03/19/09, Dr. wrote a letter of non-certification for the surgery. On 04/07/09, Dr. also wrote a letter of non-certification for the shoulder surgery. On 05/04/09, Dr. felt the patient had indications for an acromioplasty per the ODG. On 05/29/09, Dr. referred the patient to a pain management specialist and also recommended psychological/emotional support and Phenergan.

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

The patient was injured on xx-xx-xx. An MRI of 01/19/09 showed mild subscapularis and supraspinatus tendinopathy without evidence of any partial

high grade or full thickness rotator cuff tear. She underwent a Cortisone injection on 02/27/09 that provided minimal relief of short duration. According to the ODG, three to six months of conservative care is recommended to include physical therapy and an injection, which the patient received. She also has subjective clinical findings of pain with range of motion and pain at night. She also has tenderness over the anterior acromion and a positive impingement sign. She also received transient relief from the Cortisone injection. Therefore, based on the ODG and the clinical findings noted above, the requested left shoulder arthroscopy with subacromial decompression is reasonable and necessary and the previous adverse determinations are overturned.

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 AND KNOWLEDGE BASE
- 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)**