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Notice of Independent Review Decision

DATE OF REVIEW: 06/18/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a right shoulder arthroscopy (29805).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 15 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a right shoulder arthroscopy (29805).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
MD.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: summary of IRO dated 6/7/10, 5/14/10 denial letter, 5/7/10 appeal of denial, 12/29/09 to 4/19/10 progress notes, 5/13/09 MRI report of right shoulder, 11/27/09 to 12/11/09 reports by MD, 11/13/09 script by Dr., 11/13/09 sonographic report of shoulder and wrist, 11/4/09 PPE report, 11/16/09 procedure note, 11/17/09 procedure permission slip, 10/30/09

radiographic report, 11/3/09 to 12/3/09 treatment plans and 3/18/10 IRO decision.

6/8/10 letter by, 6/7/10 IRO summary, 3/27/09 associate statement, 9/29/09 CCH report, various DWC 73 forms, notes from 3/27/09 to 4/2/09, 3/27/09 E1, 4/14/09 to 12/21/09 PLN 11 forms, 4/7/09 to 7/2/09 reports from Healthcare, 4/10/09 to 5/15/09 OT reports by, 4/13/09 to 6/2/09 reports from Rehabilitation, 4/20/09 report by MD, 5/1/09 FCE report, 5/20/09 neurodiagnostic report, 5/21/09 clinical interview by LPC, 6/5/09 FCE report, 6/14/09 ER records from Hospital, 6/30/09 to 10/08/09 reports by, 6/30/09 patient intake paperwork, 6/30/09 report by MD, 7/7/09 TENS unit rental agreement, 7/27/09 FCE report, 7/31/09 report by MD, 8/10/09 Dallas Co physicians statement, 8/26/09 to 9/9/09 reports by MD, 9/17/09 FCE, DD report by MD of 10/16/09, 10/30/09 to 2/1/10 reports by MD, 12/9/09 report by N Tsourmas MD, 4/8/10 behavioral medicine eval, 4/29/10 preauth request, 6/5/10 report by MD, 4/3/10 preauth request, 4/19/?? Script for right shoulder scope, 5/7/10 appeal letter by, 4/29/10 denial letter and 5/14/10 denial letter.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The female claimant has a persistently painful right shoulder status post a fall while working. Despite the passage of time and extensive therapy, and at least one subacromial injection (on 4/5/10). A 7/31/09 dated evaluation documented a probable lack of cooperation on the physical exam as prior evaluators had documented significantly greater motion. Subjective complaints were noted to be markedly disproportionate to exam findings and that there was no ongoing pathology related to the DOI (at the shoulder level) as per a Dr. The injury mechanism provided was noted to be quite vague, in addition. On 12/9/09, A Dr. documented that treatment had been “excessive” for a simple sprain. On 12/11/09, a Dr. noted negative impingement, diffuse shoulder tenderness and a shoulder sprain diagnosis. Deltoid atrophy, tenderness and impingement were noted on 4/5/10 and 4/19/10 by another provider. The claimant has a persistently painful arc of motion, shoulder weakness and impingement. A 5/13/09 dated MRI reflected only tendinopathy and AC arthrosis. The 6/7/10 dated letter of appeal was reviewed. The 3/16/10, 4/2/ 10 and 5/14/10 denial letters were reviewed with rationale being the lack of deltoid atrophy, failure of reasonable non-operative treatment or MRI-associated structural lesion. A 9/14/09 dated reference to a prior cortisone injection was noted.

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

The reviewer notes the conflicting exam findings (between evaluators), the incomplete cooperation with at least one physical exam of the shoulder, the vague injury mechanism and subjective complaints disproportionate to exam

findings support the lack of any consistent shoulder functional limitations. The minimally remarkable and fully conclusive MRI is further support for the lack of indication for shoulder arthroscopic surgery at this time.

Reference: ODG guidelines: Diagnostic shoulder arthroscopy:
Criteria for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear.

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)**