

SENT VIA EMAIL OR FAX ON
Sep/30/2010

IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder Arthroscopy

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

Doctor of Medicine (M.D.), Board Certified in Orthopaedic Surgery, Fellowship Training in Upper Extremities

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

OD Guidelines

Denial Letters 9/1/10 and 8/16/10

Dr. 7/1/10 thru 8/19/10

7/1/10 thru 8/19/10

MRI 6/22/10

PATIENT CLINICAL HISTORY SUMMARY

The patient tripped and fell at work injuring his right hand and shoulder. The patient also appears to have had an injury to the cervical spine and has complaints of hand paresthesias and neck pain. Physical examination by the requesting surgeon shows neck pain and axial compression causing paresthesias in the hand. A complete neurological examination was not included. The requesting surgeon does note a positive Spurling's test to the right as well as motor weakness but does not describe a specific myotome. The patient has had two subacromial steroid injections with temporary relief of symptoms. Physical examination of the shoulder is consistent with impingement syndrome. The patient has not responded well to physical therapy. The insurance company has denied the request for shoulder arthroscopy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

The IRO reviewer agrees with the insurance company's denial of shoulder arthroscopy. The surgeon is requesting three CPT codes for the procedure. The 1st is an extensive debridement, the 2nd is an acromioplasty, and the 3rd is an unlisted procedure is not described in the surgeon's notes in any form. Based on the medical records provided, this patient's pain syndrome has not been adequately worked up. The patient requires a cervical MRI and possibly and nerve conduction study/EMG if true motor and sensory abnormalities are present. In addition, the unlisted procedure that is requested needs to be elucidated and spelled out in the surgery request form/preauthorization request as well as in the surgeon's dictation to describe what unlisted procedure he is seeking preauthorization for. The request is not medically reasonable or necessary based on the above rationale.

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)