



**Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)**

DATE OF REVIEW: 09/09/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right Shoulder Arthroscopic Debridement

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

Board Certified in Orthopaedic Surgery
Certified in Evaluation of Disability and Impairment Rating -
American Academy of Disability Evaluating Physicians

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.

Right Shoulder Arthroscopic Debridement - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Progress Notes, M.D., 01/15/08, 02/12/08, 02/25/08, 03/05/08, 03/12/08, 03/26/08, 04/24/08, 05/02/08, 05/09/08, 05/16/08, 06/11/08, 06/25/08, 07/25/08, 08/25/08, 09/30/08, 12/03/08
- DWC Form 73, Dr., 01/15/08, 02/12/08, 02/25/08, 03/05/08, 03/12/08, 03/25/08, 05/02/08, 05/09/08, 05/16/08, 06/11/08, 06/25/08, 07/28/08, 08/25/08, 09/30/08
- Right Scapula X-Ray, Dr., 02/12/08, 08/25/08
- MRI Right Shoulder, M.D., 02/29/08
- Chest X-Ray, M.D., 04/18/08
- History & Physical, Dr., 04/24/08
- Operative Report, Dr., M.D., 04/24/08
- Initial Evaluation Report, D.C., 08/19/09
- Office Visit, M.D., 12/15/09, 03/16/10
- Bone Scan, M.D., 01/12/10
- Statement of Medical Necessity, Dr., 01/15/10

- Peer Review, M.D., 01/25/10
- MRI Right Shoulder, Dr., 02/17/10
- Evaluation, Dr., 06/03/10
- SOAP Report, Dr., 07/13/10
- Pre-Authorization Request, Dr., 07/23/10, 08/03/10
- Denial Letter, 07/28/10, 08/10/10
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was injured when she was knocked down by a hog, which resulted in subsequent complaints of pain in the abdomen and right upper extremity/shoulder. She was apparently initially treated by Dr. and x-rays reported no obvious fracture. She had been prescribed Ultram and Ketorolac. She was started on a home exercise program and over-the-counter (OTC) medications by Dr.. An MRI of the right shoulder showed a high grade partial tear distal supraspinatus tendon. There could be a full-thickness communication, as articular and bursal surface involvement was indentified. There was also associated tendinosis. Her right shoulder was then injected, in which she reported relieved her pain for approximately two hours. She then underwent a repair of the right shoulder rotator cuff tear and release of coracoacromial ligament. After surgery, she was started on a home rehabilitative program. She continued to have pain and a bone scan performed was essentially normal, as well as an MRI of the right shoulder. A right shoulder arthroscopy was then requested.

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

The patient hit a fence with the posterior aspect of her right shoulder. Dr. noted on x-ray in February 2008 there was no obvious fracture of the acromion or the proximal humerus with a type II acromion and good maintenance of her acromiohumeral head interval. Her range of motion improved with physical therapy. An MRI of the right shoulder on 02/29/08 demonstrated a high-grade partial tear, involving the distal supraspinatus tendon. Her pain was relieved by a subacromial injection. On 4/28/08, , M. D. performed repair of right shoulder rotator cuff tear and release of coracoacromial ligament, and the patient finished her treatment without difficulty and was placed at Maximum Medical Improvement (MMI) by the treating provider. In August 2009, the patient started treatment with, D.C. who requested an essentially normal whole body bone scan. A repeat MRI performed on 02/17/10 of the right shoulder was normal as well, specifically; there is no tear of the rotator cuff. Nonetheless Dr. has requested a right shoulder arthroscopic surgery though his voluminous record shows no obvious pathology.

Right Shoulder Arthroscopic Debridement is neither reasonable nor necessary. There is no objective source of the patient's pain. There is no evidence of conservative treatment such as physical therapy, activity modification or medications in these records. There has been a psychological evaluation for "chronic pain." At this time the criteria for shoulder arthroscopy has not been met: There is no documentation of pain with active arc motion

90 to 130 degrees, imaging does not demonstrate positive evidence of deficit in rotator cuff and there is no evidence of weak or absent abduction.

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)
- AMA GUIDES 5TH EDITION