

# I-Decisions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE OF REVIEW:

Sep/10/2010

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Shoulder Arthroscopy, Manipulation, Decompression of Subacromial Space, and Extensive Debridement

### 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

American Board of Orthopaedic Surgery

Upper Extremity Specialist

### 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: Shoulder, Indications for Surgery

IMO, 7/26/10, 8/10/10

Orthopedic Sports Medicine, 4/28/10 to 8/11/10

Diagnostic Imaging, 6/11/10

PTC, 6/14/10, 6/30/10

### PATIENT CLINICAL HISTORY SUMMARY

The patient has chronic left shoulder pain after a work-related injury. The patient has failed conservative care including physical therapy, rest, activity modification, medical management, and two steroid injections. Physical therapy documentation shows that the patient's range of motion is progressively improving. The patient continues to have pain in the shoulder with overhead activity. The patient's last range of motion measurements by the physical therapist were: 168° of forward flexion, 165° of abduction, 88° of external rotation and 60° of internal rotation. Because of continued pain, the treating orthopedic surgeon is requesting shoulder arthroscopy with extensive debridement, manipulation under anesthesia, acromioplasty, and distal clavicle resection. The insurance company has denied the request as not medically necessary.

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

The medical documentation provided by the surgeon as well as physical therapy notes does not confirm the diagnosis of adhesive capsulitis. In addition, the MRI scan obtained does not demonstrate significant intra-articular pathology to warrant extensive debridement.

Therefore, this request for surgery does not conform to ODG indications for surgery based on the medical documentation provided. The reviewer finds that medical necessity does not exist for Left Shoulder Arthroscopy, Manipulation, Decompression of Subacromial Space, and Extensive Debridement.

**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)