

SENT VIA EMAIL OR FAX ON  
Sep/22/2010

## Pure Resolutions Inc.

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/22/2010

**IRO CASE #:**

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

Subacromial Decompression

**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

**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 7/28/10 and 6/28/10

Physicians 6/28/10 and 7/28/10

Orthopaedic Specialists 4/20/10 thru 7/20/10 Neuroradiology Report 6/24/09 Expert Review 7/22/??

Medical 1/7/02

PT Select 1/7/10 thru 5/20/10

Dr. 6/14/10

Radiology 10/10/02

**PATIENT CLINICAL HISTORY SUMMARY**

The patient has a history of two prior shoulder arthroscopic decompressions. These were performed by another surgeon. The patient has seen multiple shoulder experts including Dr. and Dr. in. Multiple records show significant symptom magnification in this patient. The requesting provider has performed intra-articular and subacromial steroid injections in this patient. The patient continues to complain of shoulder pain. MRI scan shows tendinosis with no evidence of rotator cuff tear. Ultrasound scanning shows evidence of bursal sided tearing according to the requesting physician.

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

The medical records provided by the requesting surgeon are incomplete with regards to thoroughly commenting on why this patient is a candidate for another arthroscopic shoulder decompression. The previous surgeons notes are not included and do not appear to be in the requesting surgeons medical record. There is no mention of review of the prior surgeries, prior consultation with other shoulder surgeons, or comments made by multiple independent physicians on the patient's symptom magnification and inability to perform physical examination do to poor patient cooperation. In addition, there is not a significant discussion

on the results of the intra-articular and subacromial steroid injections. The request for another arthroscopic shoulder surgery does not appear to be medically reasonable or necessary. The request does not meet the ODG guidelines for subacromial decompression.

**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)