

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 09/10/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Repeat Shoulder Arthroscopy -29807

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

Texas Board Certified Orthopedic Surgeon

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. MRI of right shoulder without contrast, 07/05/05
2. , M.D., 03/21/06
3. M.D., 08/28/06
4. Nerve conduction study, 10/12/08
5. M.D., 09/24/09, 01/07/10, 02/11/10, 04/15/10, 07/29/10
6. , 07/30/10
7. , 08/18/10

1. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The injured employee is a man who was injured on xx/xx/xx.

The employee underwent surgery for repair of a superior labrum tear. A postsurgical MR arthrogram very specifically referred to no labral defect.

All of the diagnostic procedures have referred to degenerative changes in the acromioclavicular joint and cystic changes proximally.

The injured employee saw from 09/24/09 to 07/20/10. On the last date, it was noted that he was still experiencing pain, and that he would like his right carpal tunnel done.

A physical examination by his surgeon on 01/07/10 noted full range of motion of the shoulder with pain at the extreme.

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

Official Disability Guidelines recommendations include criteria for diagnostic arthroscopy. The statement in the guidelines says diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitations

continue despite conservative care. This is not the case with this employee. He has had an essentially normal examination except for subjective complaints of pain. He had a negative MR arthrogram, a negative bone scan, and a negative EMG for radicular symptoms. The request is not certified for lack of indication.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

1. Official Disability Guidelines