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Notice of Independent Review Decision

DATE OF REVIEW: 7-31-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of left shoulder acromioplasty.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the left shoulder acromioplasty.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant sustained a left shoulder injury on xx/xx /xx. This was a lifting injury, associated with a painful pull and/or pop, on the noted date of injury. Prior treatments have included medication, therapy and injection. An MRI from 11/23/2010 was noted to reveal a lack of significant pathology, and, was read as “normal.” Electrical studies dated 12/16/2010 revealed mild bilateral carpal tunnel syndrome, without evidence of more proximal radiculopathy. X-rays have been noted to reveal a subacromial spur. The attending physician records were reviewed and were noted to be most recently from 3/14/11. The prior injection treatment “did not help.” Persistent pain with a + impingement test and subacromial tenderness were noted. The 4/24/11 dated attending physician letter reflected an opinion that the claimant had exhausted reasonable non-operative treatment and has an indication for surgery.

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

Recommend non-approval of requested service. There have been no recent records submitted for review. There has been an unreasonable gap in record of subjective and objective findings. A recent and comprehensive 3-6 months of “conservative care” (as per applicable ODG criteria) has not been documented. In addition, the claimant did not improve at all from the injection treatment, supporting a probability that surgery to decompress the same area (subacromial) would have an improbable likelihood of achieving surgical goals of pain relief and improvement of overall functionality.

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)