

**SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.**  
**12001 NORTH CENTRAL EXPRESSWAY**  
**SUITE 800**  
**DALLAS, TEXAS 75243**  
**(214) 750-6110**  
**FAX (214) 750-5825**

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Notice of Independent Review Decision

**DATE OF REVIEW:** February 16, 2011

**IRO CASE #:**

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

Right shoulder injection/Fluoroscopy.

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

DIPLOMATE, AMERICAN BOARD OF ANESTHESIOLOGY  
DIPLOMATE, AMERICAN ACADEMY OF PAIN MANAGEMENT

**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**

**PATIENT CLINICAL HISTORY:**

The description of services in dispute is right shoulder joint steroid injection under fluoroscopy. The review outcome upheld the previous non-authorization for a right shoulder injection/fluoroscopy.

The patient was injured in xxxx. The patient sustained a comminuted, displaced, angulated fracture to the mid shaft of the right radius and right ulna. The patient was referred for surgery on July 8, 2008, for open reduction and internal fixation of the right ulna shaft. The patient completed postsurgical physical therapy.

There was a functional capacity evaluation performed in August 2009. This reported near normal range of motion of the right wrist and right elbow.

The patient was placed at maximum medical improvement as of October 2009, with a 5% whole person impairment rating.

There was a physician peer review performed in February 2010, and opined that the patient's shoulder complaints were not directly related to the right forearm fracture. Furthermore, there was no mention of shoulder dysfunction prior to the 18 months following this patient's accident.

There was a right shoulder MRI performed in November 2010. This revealed a minimal degree of acromioclavicular joint hypertrophic arthrosis with 4-5 mm superior and inferior marginal bony osteophytes that may contact only the supraspinatus musculature contours. There was intact supraspinatus tendon noted, without tear and/or musculature retraction.

The current clinical examination involving the right shoulder revealed 3/4 tenderness with 30% decreased range of motion.

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

After a review of the information submitted, the previous non-authorization to perform right shoulder joint steroid injection under fluoroscopy has been upheld in accordance with ODG Guidelines, Treatment Index, 8<sup>th</sup> Edition, Webb 2010, under shoulder-injection.

According to ODG Guidelines a shoulder injection is recommended for rotator cuff disease only; corticosteroid injection may be superior to physical therapy intervention for short-term results, and a maximum of three are recommended. The submitted MRI did not reveal any rotator cuff tendinitis, tendinosis/pathology. Furthermore, from the current exam findings, the medical necessity of the request cannot be determined. Additionally, the need for fluoroscopy is in question; simple subacromial injections do not require fluoroscopy as a necessity. Therefore, in accordance with ODG Guidelines recommendations the previous non-authorization is upheld.

**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 KNOWLEDGBASE
- 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)**