



Southwestern Forensic
Associates, Inc.

REVIEWER'S REPORT

DATE OF REVIEW: 11/13/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient right shoulder arthroscopic Bankart repair, subacromial decompression, distal clavicle excision

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified in Orthopedic Surgery

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. referral
2. utilization review
3. Denial letters 08/25/11 and 09/12/11
4. Carrier records including paperwork
5. Request for IRO
6. Denial letters
7. Notes from
8. MRI report, right shoulder, 05/28/11
9. Notes from
10. MR arthrogram, right shoulder, 07/27/11, and supporting documentation
11. Physical therapy notes
12. Records from
13. EMG,
14. MR arthrogram report, 07/27/11

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The claimant suffered an injury to the back and posterior shoulder when a chair was thrown, hitting her in the back. There is no evidence of documented dislocation or previous injuries. The claimant was seen, evaluated, and treated by and then and was felt to have anterior shoulder instability and subacromial impingement. A Bankart repair, subacromial decompression, and a distal clavicle resection were recommended. The claimant failed conservative treatment, including physical therapy.

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

There is no documented dislocation in this case and the MR arthrogram findings of an anterior intralabral injury are most likely degenerative in nature. The claimant may clinically have subacromial impingement syndrome; however, there is no documented subacromial steroid injection. Therefore, the surgery is not indicated based on a lack of adequate conservative treatment, including subacromial steroid injection. The request does not conform to the Official Disability Guidelines.

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

(Check any of the following that were used in the course of your review.)

- 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 judgment, 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 national accepted medical literature (OKU Spine).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)