

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** FEBRUARY 2, 2012

**IRO CASE #:**

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

Medical necessity of proposed left shoulder arthroscopy with subacromial decompression; mini open rotator cuff repair and labrum repair (29826, 23412, 29807)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

### **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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
727.61	29826		Prosp	1			8.20.10	003531-018121wc01	upheld
718.01	23412		Prosp	1			8.20.10	003531-018121wc01	upheld
718.01	29807		Prosp	1			8.20.10	003531-018121wc01	upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Request for an IRO-18 pages

Respondent records- a total of 32 pages of records received to include but not limited to: letter 1.13.12; letters 11.23.11, 12.28.11; records 7.18.11-11.15.11; MRI Shoulder with contrast with post Arthrogram 9.15.11; Operative report 4.7.11

Requestor records- a total of 17 pages of records received to include but not limited to:

records 2.23.11-11.15.11; MRI Shoulder with contrast with post Arthrogram 9.15.11; Operative report 4.7.11

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient sustained an on the job injury on xx/xx/xxxx.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

The denial is upheld. Based upon a review of the records, including the prior surgical intervention and according to ODG guidelines, the indications for repeat surgery have not been met. There is no diagnosis or finding that would suggest a new finding or recurrent old finding that would necessitate surgery. Therefore, medical necessity for indicated repeat surgery has not been met.

**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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)