



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 12/28/2011

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of outpatient left shoulder diagnostic arthroscopy.

**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. The 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 prospective medical necessity of outpatient left shoulder diagnostic arthroscopy.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Inc., DC, MD, MD, DC, and MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: Denial Letters – 11/28/11 & 12/7/11; SORM Employee’s Report of Injury – xx/xx/xx; Imaging Cervical MRI report – 11/5/09; M MD Electro-Diagnostic Interpretation report – 1/21/10; Medical Center Diagnostic Imaging CT C-Spine and Myelogram Cervical Spine – 10/3/11; MRI Left Shoulder Arthrogram and CT Report – 10/7/11; Technologies Physical Performance Baseline Reports – 7/7/11 & 9/22/11; Chiropractic SOAP Notes – 10/16/09-1/20/10, MRI Thoracic Lumbar script – 10/29/09, Initial Examination – 10/19/09; Pneumex Measure and Analyze Posture report – 10/16/09; Dr. Fact Finding Confidential Patient Questionnaire – 10/16/09; Imaging Consultation

report – 12/2/09, Follow-up report – 12/16/09; Orthopedic Assoc. Office Notes – 1/28/10-11/2/10, MRI Left Shoulder – 2/1/10, Physical Therapy Flow Sheet – 3/3/10-6/16/10, Daily Progress Notes – 3/8/10-7/7/10; PT, OCS, CSCS Shoulder Functional Exam – 2/16/10; Occupational Therapy notes – 1/28/10-6/22/10; Orthopedic and Spine Hospital at Operative Report – 4/19/10; L Urso, PT Shoulder Evaluation Report – 5/12/10; Pain Medicine History and Physical – 10/15/10; Healthcare Rehabilitation Office Visit Notes – 11/15/10-11/4/11, Cervical Evaluation note – 7/6/11; Pain Procedure Center Procedure Notes – 12/7/10-3/17/11; RN, ANP Follow-up Visit Note – 1/12/11; PAC Exam Notes – 6/16/11; MD, Clinical Observations/Comments – 8/16/11; II, MD Follow-up Report – 8/29/11-9/12/11; Behavioral Health Therapy Notes – 8/31/11-9/15/11, Office Note – 10/8/11, Pre-Surgical Psychological Evaluation – 10/26/11; Clinic Progress Notes – 9/19/11-10/31/11; DWC69s – 10/20/10, 5/18/11, & 6/1/11, DWC73s; MD Evaluation Reports – 10/20/10-11/30/11; and Dr. MMI report/Impairment Rating – 8/1/11.

Records reviewed from: Preauthorization Request – 11/17/11, Reconsideration request – 11/29/11; Healthcare and Rehab Office Note – 9/21/09; and, MD Initial Consultation – 7/26/11.

Records reviewed from DC: Notice of Intent to Issue an Adverse Determinations – 12/10/09, 12/17/09, & 1/26/10; DC ESI request – 12/14/09, Office Visit Note – 11/23/09; Measure and Analyze Posture report – 11/23/09; various DWC73s; Chiropractic Pre-auth Request – 2/27/09; Re-exam Form for the Docs – 12/2/09; Progress Report & Patient Questionnaire – 11/23/09; Spinal Exam – 10/16/09; Musculoskeletal Exams – 10/16/09 & 11/23/09; Forte Denial Letters – 12/11/09, 12/18/09, & 1/27/10; and DWC53 – 1/22/10.

Records reviewed from MD: Fax Cover Sheet – 12/15/11

Records reviewed from MD: All records were duplicates from above.

Records reviewed from DC: Office Visit Notes – 1/26/10 - 11/15/10; WC Injury Consultation – 1/5/10.

Records reviewed from MD: Office Notes – 10/8/11 & 12/6/11 and Letter of Medical Necessity – 12/13/11

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The had sustained a neck and bilateral shoulder injury in xx/xx. On 11/5/09, a cervical MRI denoted multi-level degenerative changes. On 2/1/10, an MRI of the left shoulder revealed tendinosis and AC arthrosis, along with bursitis and bicipital tenosynovitis. This was treated arthroscopically on 4/19/10, including with a decompression, partial distal clavicle excision and debridement.

Persistent/recurrent pain developed in the left shoulder, resulting in therapy and a CT-arthrogram, the later on 10/7/11. This was read as a possible SLAP lesion with bursitis and calcification of the acromium. On 9/19/11, provider record discussed pain, poor shoulder motion and a positive drop arm sign, along with shoulder tenderness. On 11/14/11, shoulder flexion and abduction was 100-110 degrees, at Healthcare and Rehabilitation. Dr noted 50% of the preceding motion, as of 12/15/11. A 12/13/11 dated letter from a Dr. discussed his opinion that the claimant has ongoing neuropathic pain. Denial letters discussed an unknown dated interim injury to the left shoulder and/or the lack of comprehensive non-operative treatment.

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

There have not been recent consistent findings as to the source of pain generation (“neuropathic” vs. shoulder in origin). In addition, there has been a recent inexplicable discrepancy in reported left shoulder motion. Finally, there has not been a provision of actual records documenting specifics of a trial of medications and therapy and injection(s), with effect on the pain scale/visual analog scoring. With the preceding discrepancies and the lack of a trial and failure of reasonable non-operative treatment, the proposed diagnostic shoulder arthroscopy is not medically necessary at this time.

ODG Shoulder Chapter:

Criteria for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care.

**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)