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Notice of Independent Review Decision

DATE OF REVIEW: 12-29-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography.

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 injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following:

MDR paperwork with denials
utilization reviews 11-23-2011, 12-6-2011, and 12-8-2011
12-9-2011
reports 11-23-2011, 12-7-2011
letter 11-18-2011
reports 11-15-2011, 4-26-2011, 2-22-2011, 11-16-2010, 10-12-2010, 9-14-2010, 8-5-2010,
and 6-24-2010
report 7-21-2010
report 5-7-2010
A copy of the ODG was not provided by the Carrier/URA for this review

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant has had intermittent left shoulder pain post-operatively, despite increased shoulder motion and normal to near-normal (4+/5 upon elevation, otherwise 5/5) strength overall. The claimant is status post a left shoulder arthroscopic decompression, distal clavicle resection, biceps tenodesis and cuff repair on 7/21/10. The attending physician records reflect that the claimant's pain has overall decreased and the range of motion has improved and stabilized, through the progress note of 11/15/11. There was intermittent persistent pain including upon resisted elevation and abduction, abduction and flexion of 130 degrees each, and negative impingement. The shoulder was stable to stress. Denial letters reflect the stable motion and lack of objective findings of rotator cuff tear and/or internal derangement.

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

Recommend denial of requested service. With essentially normal shoulder strength and flexion, abduction of 130 degrees, negative impingement and lacking any significant trauma or objective evidence of a torn rotator cuff or labrum; the attending physician's patient has not met clinical guideline criteria for an injection for arthrogram and/or CT or MRI-enhanced arthrogram at this time. There has not been either a significant change in symptoms or evidence of internal derangement/labral tear; therefore, the proposed procedures are not reasonable or medically necessary at this time.

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)