



ALLMED REVIEW SERVICES INC

jtomsic@allmedreview.com

627 Russell Blvd.

Nacogdoches, TX 75965

936-205-5966 office

(214)802-2150 cell

(888) 272-0749 toll free

(936)205-5967 fax

Notice of Independent Review Decision Revised.

Date notice sent to all parties: 10/30/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Revision of left shoulder arthroscopy SAD and Distal Clavicle with CPT codes 29826, 29824, 29823, and 29999.

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

Texas Licensed Orthopedic Surgeon.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X- Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Review includes:

1. Denial Letter 10/8/12 and 8/18/12

2. 8/13/12 through 6/1/12
3. 7/27/12 shoulder MRI and arthrogram
4. 9/9/11 EMG/NCV upper extremity
5. 9/23/09 operative report for left shoulder

PATIENT CLINICAL HISTORY [SUMMARY]:

The sustained multiple injuries including to her left shoulder on 8-7-07. Due to failed medical intervention, she underwent a left shoulder arthroscopic surgery with decompression 9-23-09. The treating provider's records have been reviewed in detail. The records document that (postoperatively) the claimant failed treatments with medications, injections, therapy and restricted activities. A 9/9/11 dated electrical study reflected active cervical radiculopathy. The 7-27-12 dated MRI revealed a partially torn rotator cuff with arthrosis of the AC joint. The most recent AP records from 8-12 denote that the claimant has an indication for the proposed surgical intervention. Denial letters indicate a lack of recent comprehensive nonoperative treatment and/or other details regarding the prior surgical intervention at the left shoulder.

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

Overall a recent and comprehensive detailed non-operative treatment protocol has not been submitted for review. Therefore, despite the recent records evidencing left shoulder pain with positive impingement; the overall documentation does not meet the ODG guideline criteria for operative intervention as requested. Therefore at this time, the requested procedures are not reasonable or medically necessary.

IRO REVIEWER REPORT TEMPLATE -WC

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

**X-DWC- DIVISION OF WORKERS COMPENSATION
POLICIES OR GUIDELINES**

**X-MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE
IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**X- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES**