



14785 Preston Road, Suite 550 | Dallas, Texas 75254
 Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

DATE OF REVIEW: 10/19/2012

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder Acromioplasty and Excision of Distal Clavicle.

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

M.D. Board Certified in Orthopedic Surgery, Fellowship Trained Spine Surgeon.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	9/27/2012
Adverse Determination Letter	9/06/2012-9/19/2012
Medical Records Request	9/21/2012
Texas Workers' Compensation Work Status Report	8/17/2012-9/26/2012
Exam Notes	8/06/2012-9/10/2012
Letters of Appeal	8/20/2012-9/12/2012
	8/09/2012



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MRI Report	
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PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is male who sustained a right shoulder injury on xx/xx/xx while lifting and now complains of shoulder pain. The patient had a diagnostic injection with temporal relief. MRI done on 8/06/2012 showed a large spur and strain of the supraspinatus tendon. Therefore, due to the bone spur and due to the impingement and the diagnostic injection, the requesting surgeon is recommending surgical intervention.

Requesting surgeon is recommending Right Shoulder Acromioplasty and Excision of Distal Clavicle

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

Per ODG references the requested Right Shoulder Acromioplasty and Excision of Distal Clavicle is not medically necessary.

In reviewing the notes, the patient has not shown failure of conservative care. ODG recommend 3-6 months of non-operative management. From the notes reviewed it does not appear to be documentation of any consistent physical therapy.

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 KNOWLEDGE BASE
- 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