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Notice of Independent Review Decision

Date notice sent to all parties: 9/21/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder Arthroscopy, subacromial decompression, labral debridement, biceps tenodesis

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 Overturned (Disagree)

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. 8/10/12 Denial Letter
2. 8/30/12 Denial Letter
3. Office notes 8/7/12
4. Office Notes 4/30/12-7/19/12
5. MRI of shoulder
6. Duplicates of above records.

PATIENT CLINICAL HISTORY [SUMMARY]:

It has been well documented that the claimant has been evaluated and treated by multiple providers who have documented that ever since the claimant was injured while pushing a heavy cart that the claimant has had right shoulder recurrent pain. The claimant has been treated from the earliest days of his injury for a suspected "rule out labral tear" diagnosis in addition to a diagnosis of a shoulder strain. The various records have included documentation that delineates short-term physical therapy and the rationale for the short-term therapy being that the individual from the beginning essentially had well preserved range of motion. It also delineates that the injection into the posterior aspect of the shoulder had dramatically improved the results with pain reduction as compared to an injection into the region of the deltoid insertion/subacromial space. The clinical findings have been documented to reveal a positive impingement along with tenderness at the anterolateral acromion along with positive Hawkins sign. The claimant has been documented as of 08/07/2012 to have flexion to 125 degrees. The MRI dated 05/01/2012 has revealed a posterior superior labral tear with associated labral cyst. The claimant has also been documented to have been treated with a course of restricted activities and also NSAIDs, which in addition to the multiple injections and the significant passage of time along with short-term therapy "no longer help" as most recently noted on 08/07/2012. The 08/07/2012 dated findings reveal that the claimant describes the pain as "sharp and severe…worse with activities" with exam findings as noted revealing the aforementioned tenderness and reduced range of motion and

positive provocative signs of impingement at the level of the shoulder.

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

The claimant clearly has met criteria per the ODG guidelines for shoulder arthroscopic surgery, decompression, debridement, and biceps tenodesis. The claimant has a plausible labral tear, which also may warrant surgical repair. The claimant has failed reasonable nonoperative treatment including medications, injections, physical therapy and reduced activities. The claimant's subjective and objective findings do correlate with the positive MRI and the applicable ODG guidelines. The claimant has had intermittent treatment since the date of injury clearly lasting significantly greater than the minimum 3 months associated with the ODG criteria. Therefore at this time, the request for procedures are medically reasonable and necessary as per ODG guidelines including for impingement syndrome in particular and also surgery for labral tears.

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 ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES