



# INDEPENDENT REVIEW INCORPORATED

## Notice of Independent Review Decision

### REVIEWER'S REPORT

**Date notice sent to all parties:** 09/27/12

**IRO CASE #:**

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

Left shoulder injection (20610, 77003, J3301, S0020, A4550)

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

Texas-licensed M.D., board certified in neurology with added qualifications in pain management, fellowship-trained in pain medicine.

**REVIEW OUTCOME:**

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

Upheld (Agree)

**X Overturned (Disagree)**

Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Unit<sup>s</sup></i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
719.4	20610		Prosp.		07/16/12-08/14/12				Overturn
719.4	77003		Prosp.		07/16/12-08/14/12				Overturn
719.4	J3301		Prosp.		07/16/12-08/14/12				Overturn
719.4	S0020		Prosp.		07/16/12-08/14/12				Overturn
719.4	A4550		Prosp.		07/16/12-08/14/12				Overturn

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. TDI case assignment.
2. Letters of denial 07/26/12 & 08/14/12, including criteria used in denial.
3. Pain management evaluation and follow up 07/05/12 & 08/02/12.
4. Workers' compensation interim report 05/04/12.
5. Pain management office notes 01/09/12 & 12/08/11.
6. Rehab evaluation and treatment plan 03/06/12.
7. Rehab evaluation and FCE 01/19/12.

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8. MRI report 09/14/11.
9. IRO decision regarding pain management program 06/27/12.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant sustained a work-related injury in which there was impact to the left shoulder from a door, resulting in chronic left shoulder pain and decreased range of motion. The claimant underwent surgery that included arthroscopy and subacromial decompression as well as excision of corticoacromial ligament and acromioplasty but without significant reduction in pain symptomatology. Treatment has also consisted of medications and rehabilitation. It is unclear to this reviewer whether previous steroid injections have been done, but it certainly does not appear to be the case after her surgery.

Recent pain management progress notes indicate a worsening of pain symptoms as well as decreased range of motion of the left shoulder consistent with adhesive capsulitis. Also noted is weakness of the left shoulder, though it is unclear if this is "true" weakness versus give-way weakness due to pain in the left shoulder. Also noted is some decreased grip strength in the left hand and paresthesia that travel down the left upper extremity into the first three digits. An updated steroid injection into the left shoulder was requested by the treating pain physician.

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

Though the criteria cited by previous reviewers clearly summarized the equivocal findings regarding steroid injections through chronic shoulder pain, it is reasonable that an updated steroid injection now with worsening pain symptoms and decreased range of motion be worth attempting. Not only has this claimant not benefited from a surgical procedure but has also undergone treatment attempts including rehabilitation, medications, etc. Given lack of response and current presentation that not only consists of findings that can be seen with a adhesive capsulitis as well as failed response to prior treatment attempts, I believe it would be reasonable to proceed with a trial of a steroid injection.

**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)