



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**Date notice sent to all parties:** 10/8/2013

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of 1 right shoulder diagnostic arthroscopy as an outpatient.

**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.

**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 prospective medical necessity of 1 right shoulder diagnostic arthroscopy as an outpatient.

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

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed:

WC Office Visit Note – 8/9/13, 8/23/13

Specialist Consult Slip – 7/25/13

Following-Up Evaluation – 7/25/13

Physical Therapy Daily Notes – 7/26/13, 7/31/13, 8/1/13, 8/2/13, 8/7/13,  
8/8/13, 8/14/13, 8/20/13, 8/21/13, 8/22/13, 8/27/13, 8/28/13

MR Right shoulder w/o Contrast – 7/9/13

Records reviewed:

LHL009 – 9/17/13

Pre-authorization Reconsideration Request – 9/9/13

Pre-authorization Request - undated

Medical Review – 9/13/13

Denial Letters – 9/6/13, 9/16/13

Medical Review – 9/18/13

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant sustained a shoulder injury. He complained of ongoing shoulder pain despite medications and Physical Therapy and injection. There was “breakaway” shoulder weakness of 4/5 along with positive impingement and multiple tender areas, as of 8/23/13. The 7/9/13 dated shoulder MRI has revealed cuff tendinosis and bursitis, along with AC and glenohumeral arthrosis. The diagnosis included rotator cuff syndrome. Denials discussed that the MRI was highly diagnostic and that several signs pointed to potential secondary gain.

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

With highly diagnostic imaging (and significant findings of diffuse tenderness and global weakness plausibly compatible with symptom magnification); guideline indications for the request have not been met at this time. The diagnosis appears already satisfactorily established at this time. The ODG guidelines have not been met; therefore, the request is not medically necessary.

ODG Shoulder Chapter:

Diagnostic Arthroscopy: Recommended as indicated below.

**Criteria** for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear. (Washington, 2002) (de Jager, 2004) (Kaplan, 2004)

**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)**