



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 8/01/2013

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left shoulder deltoid repair.

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

M.D. Board Certified in Orthopedic Surgery and Sports Medicine Orthopedics.

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
Department of Insurance Notice of Case Assignment	7/12/2013
Adverse Determination Letters	5/22/2013-7/04/2013
Office Visit Notes	6/25/2013 5/15/2013
Office Visit Notes	06/29/2009-6/07/2011
Radiology Reports EMG and NCV Studies Report	11/06/2012 6/26/2012
Radiology Report	009/30/2007
Operative Report	12/16/2009
Clinical Note	3/17/2010-8/22/2012
Designated Doctor Examination Report	9/15/2011
Initial Report	11/15/2010
Psychological Evaluation	4/07/2010
	2/27/2007



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Triage Note /Discharge	
Office Visit Notes Report of Medical Evaluation	7/11/2007-12/12/2007 10/23/2008

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female with an injury to her left hand, wrist and shoulder sustained on xx/xx/xx. Her shoulder has been a persistent source of pain despite undergoing surgery 12/16/2009 for a left shoulder arthroscopy and open acromioplasty and distal clavicle resection. She underwent post-operative PT after this procedure but never seemed to improve from it. At the present time she has pain and weakness of the left shoulder with overhead motion. Her pain level is listed at 4/10. She has decreased range of motion in the shoulder with flexion and abduction with 90 degrees of motion in each of these planes according to her last clinic note. She has positive impingement tests as well as a positive empty can test. By exam she is said to have a palpable defect in her deltoid. She has had at least 2 steroid injections post-surgery that have had minimal effect. There is no documentation of recent physical therapy, although it is mentioned in one clinic note, or any other recent conservative treatment other than the steroid injections. She had a post-surgery MRI 11/6/2012 that showed widening of the AC joint consistent with prior surgery with posterior and inferior dislocation of the distal clavicle producing impingement on the supraspinatus, tendonosis of the supraspinatus, subdeltoid /subacromial bursitis, a possible posterior labral tear, and biceps tenosynovitis.

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

Per ODG references, the requested "Left Shoulder Deltoid Repair" is not medically necessary. Deltoid origin disruption is a known complication of open acromioplasty and rotator cuff repair. In this patient, the lack of objective imaging evidence of a deltoid disruption to prove this as a potential source of her pain has still not been addressed in terms of any new information from the requesting provider. I also concur with the previous assessment that -- given the amount of time that has passed from her original surgery -- any injury that occurred to her deltoid as a result of that procedure is now long standing and the likelihood of affecting a meaningful repair would be low. Lastly, there is no documentation of any recent attempts (in the past couple years) at physical therapy or other non-operative management other than injections. For these reasons I concur with the previous decisions and the requested operation is not medically necessary.



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**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