

MAXIMUS Federal Services, Inc.  
11000 Olson Drive, Suite 200  
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Tel: [800] 470-4075 ♦ Fax: [916] 364-8134

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**Notice of Independent Review Decision**

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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** November 15, 2010

**IRO CASE #:**

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

Left shoulder arthroscopy with rotator cuff repair and labral 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.

**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)

Left shoulder arthroscopy with rotator cuff repair and labral repair is medically necessary for treatment of the patient's medical condition.

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

1. Request for a Review by an Independent Review Organization dated 10/12/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Medical Review Organization (IRO) dated 10/18/10.
3. TDI Notice of Assignment of Independent Review Organization dated 11/8/10.
4. Medical records from Dr. dated 6/23/10, 7/28/10 and 9/14/10.
5. Authorization request form dated 9/15/10.
6. Physical Therapy Initial Examination dated 10/8/10.
7. Report from Dr. dated 7/14/10.
8. Decision and Order of Texas Department of Insurance Division of Workers' Compensation dated 5/6/10.
9. Denial documentation.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

A male patient has requested authorization and coverage for left shoulder arthroscopy with rotator cuff repair and labral repair. The Carrier has denied this request indicating that the requested service is not medically necessary for treatment of the patient's shoulder pain.

A review of the record indicates the patient sustained an injury on xx/xx/xx. The patient was pulling a large lever to release a valve when it sprung forward hitting him in the left shoulder (in the anterior shoulder) knocking him backwards. By report, an MRI revealed a SLAP lesion, a superior glenoid labral tear as well as an acromiale AC joint arthropathy, subacromial and subdeltoid bursitis, supraspinatus tendinosis and bursal surface partial-thickness tear. The patient's provider indicates all of these are "acute on chronic type of pathologies with exception of this labral tear, which is most likely an acute pathology related to the injury." The patient has undergone physical therapy and has been treated with injection therapy, NSAIDS and pain medication. Pain and decreased range of motion persist. The patient's provider has recommended left shoulder arthroscopy with rotator cuff repair and labral repair.

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

I find the proposed surgical intervention (left shoulder arthroscopy with rotator cuff repair and labral repair) is medically necessary for this patient. The mechanism of injury is consistent with the rotator cuff and labral injury sustained by the patient. The records indicate the patient has failed most conservative options attempted to date including physical therapy, steroid injection therapy, NSAIDS and pain medications. As such, he is an appropriate candidate for the proposed

surgery. Left shoulder arthroscopy with rotator cuff repair and labral repair is medically necessary for this patient as his condition is not likely to respond to further attempts at conservative measures. The proposed procedure is medically indicated to relieve pain and improve range of motion and is consistent with medical judgment, clinical experience and expertise in accordance with accepted medical standards in this setting.

**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)