

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/31/2010

**IRO CASE #:**

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

29827 Arthroscopic Left Shoulder Rotator Cuff Repair; 29807 Arthroscopic Left Shoulder Superior Glenoid Labrum Repair; 29823 Arthroscopic Left Shoulder Debridement, Extensive

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

M.D., Board Certified Orthopedic Surgeon

**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**

ODG-TWC Treatment Guidelines  
Work Status reports  
Employer Injury Report  
Range of motion testing reports, 7/22/09-9/30/10  
05/10/09 Regional Medical Center records  
Records of Dr. 05/11/09, 05/18/09, 06/11/09  
Physical therapy notes, 5/21/09-6/16/10  
06/19/09 MRI left shoulder report  
6/23/10 MRI left shoulder post arthrogram  
Records of Dr., 07/22/09, 08/12/09  
08/25/09 record review  
10/20/10, 11/16/10 peer reviews  
Summary, 12/20/10  
Shoulder Arthroscopy  
Injection/Arthrogram, 6/23/10  
Injection, 8/12/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a female with complaints of left shoulder pain following being struck by shopping cart on xx/xx/xx. The claimant presented to the emergency room the same day. Left shoulder tenderness with full range of motion was noted. Reportedly cervical spine x-rays were negative. Diagnosis was contusion to the left shoulder. Medications were recommended. The

claimant treated with Dr. on xx/xx/xx and 05/18/09 for continued left shoulder pain. Physical therapy and continued medications was recommended. The claimant treated with both physical therapy and a chiropractor in 2009. The MRI of the left shoulder from 06/19/09 showed mild supraspinatus tendinopathy with partial bursal surface tear of the supraspinatus tendon and mild infraspinatus tendinopathy. Mild acromioclavicular osteoarthritis was noted. On 07/22/09, Dr. evaluated the claimant. Diagnosis was left shoulder partial cuff tear and impingement. Antiinflammatory medications were recommended. It was also noted that the claimant was status post injection 08/12/09. On 08/13/09, Dr. recommended work restrictions.

The claimant underwent 2/15/10 arthroscopic shoulder surgery for partial supraspinatus tear and SLAP repair. She participated in 24 physical therapy sessions post surgery. A left shoulder arthrogram was performed on 06/23/10. Impression was no rotator cuff tear identified and mild irregularity of the synovial lining perhaps representing mild synovitis. Recommendation was made for chronic pain management or surgery. The patient was unsure if she wanted to pursue further surgical intervention. She had 4 sessions of individual counseling starting in August 2010. Note dated 9/20/10 states the patient does not wish to pursue surgery. Note from the Orthopedic Clinic states the patient is felt to not be a pain management candidate at this time, and "will request arthroscopy and repair." A peer review analysis dated 11/26/10 states that the records "continue to document complaints and creative iatrogenia, as opposed to any identifiable specific, credible evidence of any actual specific challenge/injury to cells, tissues or structures. The claimant was simply knocked down to the ground, she had contusions, and these contusions probably inexorably resolved within 30 days...I agree with Dr. that it is hardly likely that the findings of the MRI are due to injury, as opposed to the ordinary diseases of life....There simply is no objective physical, medical or scientific evidence of any injury beyond assumed contusions."

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

The requested arthroscopic left shoulder rotator cuff repair, glenoid labrum repair and extensive debridement is not medically necessary based on review of this medical record. It would appear from this medical record that this is a female who works as a . She was injured xx/xx/xx when she was hit by shopping carts and knocked to the ground. There are medical records from xx/xx/xx onward documenting her left shoulder complaints and treatment. She was treated conservatively. She is status post 02/15/10 left shoulder surgery. The ODG Guidelines for rotator cuff repair surgery indicate the need for an abnormal diagnostic test showing the rotator cuff tear that has failed appropriate conservative care. A left shoulder arthrogram was performed on 06/23/10. Impression was no rotator cuff tear identified and mild irregularity of the synovial lining perhaps representing mild synovitis. The reviewer finds no medical necessity exists at this time for 29827 Arthroscopic Left Shoulder Rotator Cuff Repair; 29807 Arthroscopic Left Shoulder Superior Glenoid Labrum Repair; 29823 Arthroscopic Left Shoulder Debridement, Extensive.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)