

SENT VIA EMAIL OR FAX ON  
Jun/03/2011

## True Decisions Inc.

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/03/2011

**IRO CASE #:**

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

Outpatient right shoulder arthroscopy, labrum repair and subacromial decompression

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

Texas Licensed 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

1. Clinical records Dr 02/03/11, 03/07/11, 03/25/11
2. Clinical records Dr. dated 04/15/11, 04/29/11
3. MR arthrogram right shoulder dated 03/29/11
4. Utilization review determination dated 04/22/11
5. Utilization review determination dated 05/06/11
6. Physical therapy treatment records
7. Utilization review determination dated 03/17/11
8. Utilization review determination dated 02/11/11
9. Request for IRO

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a XX year old male who developed right shoulder pain as a result of loading tires onto truck on XX/XX/XX. His pain started when he threw a tire up over his head. He subsequently developed burning sensation and had limited range of motion. He came under the care of Dr.. On 02/03/11 it is noted the claimant has pain to palpation to anterior shoulder. Abduction is to 80 degrees laterally and anteriorly range of motion is about the same. Internal and posterior rotation is diminished on the right when compared to left. He was diagnosed with right shoulder strain and mild rotator cuff strain versus early impingement. He was treated conservatively with oral medications and referred for physical therapy. Records indicate the claimant completed 12 sessions. He is noted to have pain at very distal point of shoulder with posterior and anterior rotation. He received a corticosteroid

injection. The claimant was subsequently referred to Dr. on 04/15/11. The claimant reported right shoulder pain, difficulty with movement, popping upon occasion. He has difficulty raising his arm overhead. He has had 12 sessions of physical therapy and cortisone injection. He is currently working full duty but is modifying his activities. MRI dated 03/29/11 indicates there was MRI arthrogram of the right shoulder. This study notes a niche of contrast in the superior labrum consistent with SLAP tear. The biceps labral complex is intact. There is no high grade partial or full thickness rotator cuff tear noted. There is some tendinopathy signal seen in the distal rotator cuff. Some hypertrophy is present at AC joint with edema and subchondral bone. The acromion is type I. Subscapularis and teres minor are intact. On physical examination he is reported to have good range of motion of right shoulder. He does not have a frozen shoulder. He complains of pain with elevation of arm above shoulder level. There is palpable crepitus. His pain and crepitus increase with rotating the shoulder with arm in overhead position. He can touch the opposite shoulder. He can place hand behind his back and head. He is recommended to undergo a right shoulder examination under anesthesia, arthroscopy, labral repair and subacromial decompression. The claimant was subsequently seen in follow-up on 04/29/11. It is noted the request for surgery was not approved. Dr. reports that the type of labrum tear was not described. To his knowledge, the type of tear cannot be determined on MRI scan only at the time of arthroscopy. It is reported he is beginning to lose motion. He is reported to have seen Dr. for pain control. He indicates the claimant has failed conservative treatment and recommended surgical intervention.

The request was initially reviewed on 04/22/11 by Dr.. Dr. opines that the type of SLAP lesion has not been adequately identified and indicates type I and type III lesions do not need any treatment or are debrided, whereas type II and IV lesions are repaired.

The appeal request was reviewed by Dr.. Dr. notes that the MR arthrogram notes the biceps labral complex to be intact which would suggest this is not type II or IV lesion. He noted there is tendinopathy and partial tears of cuff but only 25%. He notes while the claimant has had injections, there is no documentation of the claimant's response. He further notes that based on the data, impingement does not appear to be a problem, and there has been no intraarticular injection to see if SLAP is symptomatic. He noted that the comment that SLAP can only be categorized by arthroscopy is not entirely true since the biceps muscle complex could be seen well enough to note it was not torn loose. He notes if there is some loss of motion (i.e. early adhesive capsulitis) that it would not be a good time to consider surgery as stiffness may prove to be difficult postoperatively. He opines the claimant does not meet guidelines under several areas noted above. He further reported the mechanism of injury is not consistent with development of SLAP lesion.

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

The request for outpatient right shoulder arthroscopy, labral repair, and subacromial decompression is not supported by the submitted clinical information. The record indicates the claimant sustained an injury to his right shoulder and has undergone 12 sessions of physical therapy and received corticosteroid injection. MR arthrogram suggests possibility of SLAP lesion and notes the biceps labral complex is intact. There is no high grade partial or full thickness rotator cuff tear noted, and there is tendinopathy in the distal rotator cuff. There is no evidence of impingement on physical examination, and it does not appear the claimant has a type II or IV SLAP lesion present which would require operative intervention. Based on the clinical information provided, the conclusions of the previous reviewing physicians are appropriate, and the previous determinations should be upheld.

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

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**