

SENT VIA EMAIL OR FAX ON  
Oct/13/2011

## Pure Resolutions Inc.

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Oct/13/2011

**IRO CASE #:**

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

1 Right Shoulder Arthroscopy with Superior Labrum Anterior Posterior (SLAP) Repair and Exploration of Subacromial Decompression; 1 Assistant Surgeon

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

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**

OD Guidelines

Request for IRO dated 09/26/11

Request for IRO dated 09/27/11

Utilization review determination dated 09/02/11

Utilization review determination dated 09/23/11

Designated doctor evaluation dated 02/09/10

Operative report dated 06/21/10

Clinic note Dr. dated 08/02/10

Functional capacity evaluation dated 04/13/11

Clinical records Dr. dated 07/15/11, 08/26/11

MR arthrogram dated 08/18/11

MRI right shoulder dated 08/18/11

Utilization review determination dated 09/02/11

Utilization review determination dated 09/23/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who is reported to have sustained work related injury on xx/xx/xx. It is reported on the date of injury he tripped and landed on his right side. He initially received treatment at Medical Center. He subsequently was taken to surgery on 06/21/10 by Dr. and underwent a right shoulder arthroscopy with subacromial decompression and debridement of

partial rotator cuff tear. Records indicate the claimant was referred for EMG and was seen in follow up on 02/10/11. Study is reported to be normal. Records indicate that on 04/14/11 the claimant was referred for a functional capacity evaluation. Upon completion of this the claimant was found to be capable of performing work at a heavy physical demand level.

On 07/15/11 the claimant was seen by Dr. He presents for consultation regarding injuries to his right hip and shoulder. The claimant reports that he was initially treated at medical center evaluated x-rayed and released. He was placed in a physical therapy program. He was later seen by Dr. who evaluated the claimant and obtained an MRI. He was then seen by Dr. and ultimately underwent a right shoulder arthroscopy. He presents with intermittent right shoulder pain which seems to increase with activity level and he has complaints of right hip pain. On physical examination he experiences some difficulty getting out of the chair on the examination table due to the pain in his hip. On examination he has tenderness over the greater trochanter. He has pain with internal and external rotation. His abduction and adduction were appropriate. He had paresthesias along the lateral aspect of the right lower extremity into his foot. His gait was slow. He was able to heel toe walk. On examination of the right shoulder he has three well healed arthroscopic incisional sites tenderness over the anterolateral aspect with limited range of motion with abduction of approximately 130 degrees. He had full external rotation limited internal rotation of approximately 15 degrees. He has positive left off side on the right and positive drop arm test on the right. He had positive impingement sign noted. Radiographs performed at this visit show no bony abnormalities. It is reported to have persistent right shoulder pain. It was subsequently recommended that the claimant undergo an MR arthrogram of the shoulder. This was performed on 08/18/11. This study notes a type 2 acromion with advanced acromioclavicular osteoarthritis which does not significantly encroach on the supraspinatus outlet a mild os acromial is identified. The supraspinatus there is distal supraspinatus tendinosis and a tiny intrasubstance partial thickness tear with distal supraspinatus tendon suggested. The remainder of the tendons are intact. There are tiny T1 T2 hypointense foci in the long biceps tendon sheath posterior glenohumeral joint just inferior to the superior labrum which probably represent small foci of iatrogenic air. But tiny loose bodies may also have a similar appearance acromioclavicular osteoarthritis. On 08/26/11 the claimant was seen in follow up by Dr. On examination he is reported to have anterolateral tenderness pain with abduction limited range of motion to approximately 130 degrees positive speed's test pain with biceps stretching. Dr. opines that the MRI MR arthrogram showed increased signal near the superior labrum which he believes is consistent with a possible SLAP tear. He subsequently recommends surgical intervention.

On 09/02/11 the initial review was performed by Dr. who non-certifies the request and reports that the submitted clinical records fail to document the exhaustion of conservative treatment. There's no data regarding injections. He further notes that it is unlikely there will be further gain with additional surgery. The appeal request was reviewed on 09/23/11 by Dr. who conducted a peer to peer with Dr. who indicated that there was evidence of labral tear on MR arthrogram. Dr. discussed the findings on the MR arthrogram and notes that there is no indication of a labral tear and subsequently notes that claimant's undergone a functional capacity evaluation which notes he can function a heavy physical demand level and subsequently non-certifies the request.

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

The request for right shoulder arthroscopy with superior labrum anterior posterior repair and exploration subacromial decompression assistant surgeon is not medically necessary and the prior utilization review determinations are upheld. The submitted clinical records indicate that the claimant sustained an injury to his right shoulder as a result of work related activity. He subsequently underwent a course of conservative treatment but was ultimately taken to surgery by Dr. on 09/21/10. The claimant underwent a subacromial decompression with debridement of partial rotator cuff tear. The claimant is reported despite having undergone surgery the claimant is reported to have had continued pain in the shoulder. It's noted that the claimant ultimately underwent a functional capacity evaluation on 04/14/11 indicating that

he can function at a heavy physical demand level. The claimant subsequently sought care from Dr. who notes that the claimant has limited range of motion and abduction of approximately 130 degrees with full external rotation limited internal rotation of 15 degrees positive lift off positive drop arm on the right with positive impingement sign. He subsequently recommended that the claimant undergo MR arthrogram which was performed on 08/18/11 and shows no significant findings. There's evidence of osteoarthritis with some residual tendinosis without evidence of a labral tear. The clinical notes as presented do not indicate that the claimant has undergone any form of conservative treatment in the interval period between his initial surgery and subsequent request for additional surgery. Therefore given the lack of pathology noted on MRI noting that the claimant is able to perform at a heavy physical demand level and the lack of documentation to establish failure of adequate interval conservative management request is not medically necessary.

**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)