

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/26/2011

**IRO CASE #:**

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

Outpatient surgery left shoulder EUA arthroscopy with Debridement SAD Mumford RCR

**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**

Official Disability Guidelines

Adverse Determination Letters, 12/02/11, 11/03/11

Precertification request 10/28/11

Reconsideration request 11/07/11

Impairment rating exam D.C. 12/01/08

Orthopedic clinic notes M.D. 02/10/09-10/28/11

X-rays left shoulder 09/24/10

Physical therapy service plan of care / reevaluation 12/08/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male whose date of injury is xx/xx/xx. He was injured secondary to electric shock / fall from ladder. X-rays of left shoulder performed on 09/24/10 revealed old fracture deformity of mid shaft of left humerus. There is no acute fracture, dislocation or other acute osseous pathology. Left AC joint, shoulder joint, and soft tissues appear otherwise unremarkable. The claimant was seen on 10/28/11 for follow-up of left shoulder. He underwent EUA and MUA in 06/08. The claimant states his shoulder is still bothering him especially with overhead maneuvers. Examination reported the claimant to be 5'6" tall and 227 lbs. Upper extremity examination reported persistent tenderness over AC joint, positive Neer and Hawkins impingement signs. Range of motion testing reported AAT 150 degrees with discomfort past 125 degrees. There was 4+/5 strength on drop arm test, equivocal O'Brien's test, and painful speed test. No radiology report was submitted for review, but previous MRI was noted to reveal signal changes in AC joint and rotator cuff. Surgical intervention to left shoulder has been recommended.

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

This man was treated conservatively with medications, physical therapy, activity modification,

and HEP. MRI reportedly revealed changes in AC joint and rotator cuff, but no radiology report was provided. Per ODG guidelines, there should be evidence of failure of at least 3-6 months of conservative treatment including stretching and strengthening to balance musculature. There is no documentation of adequate conservative treatment. Per physical therapy reevaluation note dated 12/08/11 the claimant had received only 4 physical therapy treatments since initial evaluation on 09/30/11. There is no documentation of subjective findings including painful active arc of motion from 90-130 degrees and night pain, as well as objective clinical findings including temporary relief of pain with anesthetic injection (diagnostic injection test) and imaging/clinical findings. Accordingly, the reviewer finds medical necessity has not been established for Outpatient surgery left shoulder EUA arthroscopy with Debridement SAD Mumford RCR.

**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)