

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Mar/20/2012

**IRO CASE #:**

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

Arthroscopy Right Shoulder Neer Acromioplasty

**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 and Treatment Guidelines

Request for IRO 03/01/12

Utilization review determination 03/01/12

Utilization review determination 02/06/12

Letter of appeal

Clinical records 08/30/11

Physical therapy treatment records

Clinical records 09/14/11-12/08/11

Clinical note 09/28/11-10/27/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who has a date of injury of xx/xx/xx. He was reaching for an object and when he pulled his arm back his shoulder popped. He was evaluated by on 08/30/11. He was getting down an axe out of an attic, and when the accident occurred he had immediate pain. He has pain in the shoulder with flexion extension, external and internal pain in the shoulder with all range of motion. He has decreased range of motion in all planes. He has decreased grip strength. Rotator cuff strain radiographs of the shoulder were unremarkable. He has been given oral medications and referred for physical therapy. He made some improvement with physical therapy. Per clinical note dated 10/27/11 the claimant was referred for MRI that showed a grade 1 sprain with no tears being seen. He was continued in physical therapy. He is reported to have had a history of left shoulder surgery. On 11/03/11 the claimant was referred to an orthopedist. He has tenderness to palpation over the right shoulder in the region of the supraspinatus and biceps tendon with no tenderness over the acromioclavicular joint. He has noted drop arm, decreased range of motion of the right shoulder secondary to pain with positive impingement test. He was provided with oral medications, continued in physical therapy and provided work restrictions. There was a recommendation for corticosteroid injection. The claimant was seen in follow-up on 11/17/11. He presents for administration of corticosteroid injection. The claimant was seen in follow-up on 12/08/11. The injection caused him more pain for one to two days, and

then it improved slightly, and then he returned to a base line. His provider diagnosed impingement syndrome and it was recommended that he undergo right shoulder arthroscopy with a Neer acromioplasty.

reviewed the request noting that downsloping of the acromion process was not documented and that no rotator cuff tear was demonstrated and no impingement signs were present. A subsequent appeal request was reviewed by on 01/17/12 who noted that the Official Disability Guidelines indicate that surgery can be considered if there has been continuous three months of conservative care pain with active arc of motion from 90-130 degrees as well as pain at night, as well as positive impingement sign and temporary relief of pain with anesthetic injection. He notes that imaging studies do not show evidence of impingement and that the claimant has had a corticosteroid injection and that records do not demonstrate a painful arc of motion nor do the records establish three continuous months of conservative treatment.

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

This claimant has a history of right shoulder injury while exiting an attic. He has had physical therapy. He does not appear to have consistently utilized oral medications. He has been provided work restrictions. The record does not provide radiographic evidence of impingement, nor do the serial physical examinations provide documentation establishing a painful arc of motion. The claimant has undergone a corticosteroid injection with a paradoxical response. Based upon the submitted clinical records the reviewer finds that medical necessity is not established for Arthroscopy Right Shoulder Neer Acromioplasty.

**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)