

# True Resolutions Inc.

An Independent Review Organization

500 E. 4th St., PMB 352

Austin, TX 78701

Phone: (214) 717-4260

Fax: (214) 276-1904

Email: [rm@trueresolutionsinc.com](mailto:rm@trueresolutionsinc.com)

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Sep/17/2012

**IRO CASE #:**

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

Left Shoulder Arthroscopy, Rotator Cuff Repair, Subacromial Decompression, Biceps Tenodesis Arthroscopy

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

Board Certified Orthopedic Surgeon (Joint)

**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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Cover sheet and working documents

OSA encounter notes dated 01/10/12-03/20/12

MRI left shoulder dated 03/19/12

Office visit notes M.D. 03/28/12-08/01/12

Claims Administrative Services letter dated 04/18/12

Physical therapy daily progress notes dated 04/19/12-04/25/12

Report of medical evaluation / designated doctor evaluation dated 05/18/12

Functional capacity evaluation dated 06/04/12

Therapy Referral / Hand Therapy Center dated 06/20/12

Adverse determination letter dated 07/27/12

Letter of medical necessity dated 08/01/12

Adverse determination letter dated 08/20/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who reportedly was injured on xx/xx/xx. He complained of left shoulder pain and low back pain. MRI of the left shoulder dated 03/19/12 revealed tendinopathy of the rotator cuff with a small rim rent tear in the supraspinatus segment at the footprint with minimal joint effusion and subcoracoid bursitis; no osteochondral fractures identified. There's a type 2 coracoacromial arch with AC hypertrophy and outlet impingement. Records indicate the claimant had physical therapy and stated therapy improved his condition. He had three trigger point injections to the lumbar area and arm and reported no change in condition. The claimant was seen on 07/18/12 with chief complaint of left shoulder pain. It hurts when he elevates. He feels weak. Pain does not radiate. It bothers him at night when he lays on it. Medications were listed as Naprosyn and Theragesic cream. Examination of the left shoulder reported painful arc of motion. Claimant can actively forward flex to 90 degrees, but is painful and passively he can go to 140 degrees. There is no drop arm sign. With arm to the side he externally rotates 40 degrees with pain. He has positive Neer and Hawkins signs. He has giveaway weakness to external rotation and abduction. Biceps are with some pain on flexion. There is good extension. Elbow is with good motion. There is negative Tinel's. forearm is non-tender. Wrist is with good motion. There is negative Phalen's and Tinel's. It was noted the claimant has failed conservative measures including medications, therapy and injections.

A request for left shoulder arthroscopy with rotator cuff repair, subacromial decompression, biceps tenodesis arthroscopy was denied per utilization review dated 07/27/12 noting that claimant does not meet Official Disability Guidelines criteria.

A reconsideration request for left shoulder arthroscopy, rotator cuff repair, subacromial decompression, biceps tenodesis arthroscopy was denied per utilization review dated 08/20/12 it was noted that the claimant had subacromial steroid injection to the left shoulder on 03/28/12 with two days of pain relief. It was further noted that the claimant had received 16 sessions of physical therapy authorized for the lumbar spine only, and left shoulder physical therapy was denied. Reviewer noted that without at least a course of physical therapy for the left shoulder, surgical treatment is premature and not medically supported.

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

Based on the clinical data provided, the request for left shoulder arthroscopy with rotator cuff repair, subacromial decompression, biceps tenodesis arthroscopy is not supported as medically necessary. The claimant reportedly was injured on xx/xx/xx. He complained of left shoulder pain and low back pain. Left shoulder MRI revealed tendinopathy of the rotator cuff with a small rim rent tear and supraspinatus segment at the footprint with minimal joint effusion and subcoracoid bursitis. Claimant had subacromial injection that provided temporary relief times two days. It was noted that the claimant had a course of physical therapy. However, the therapy progress notes indicate that treatment was directed to the lumbar spine. There is no documentation that the claimant has had a course of physical therapy addressing the left shoulder. Per Official Disability Guidelines, there should be at least three to six months of conservative treatment prior to consideration of surgery for the shoulder. The guidelines indicate that three months of conservative care is adequate if treatment is continuous and six months is required if treatment is intermittent. Noting that there is no evidence that the claimant has had physical therapy directed to the left shoulder including strengthening and stretching exercises, surgical intervention is not indicated as medically necessary. Accordingly, previous denials are upheld.

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

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

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES