

# True Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Oct/16/2012

### IRO CASE #:

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

Outpatient right shoulder examination under anesthesia (EUA), diagnostic arthroscopy with debridement, subacromial decompression (SAD), Mumford procedure and rotator cuff repair (RCR)

### 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

Multiple Texas worker's compensation work-status reports

Progress notes 01/03/10 – 07/13/12

Radiographic report 3 views right wrist 02/19/10

Certification of healthcare provider 08/18/10

Office visit notes 08/11/10 – 05/01/12

Pre-authorization request 08/13/10

Shoulder physical therapy evaluation 08/13/10

MRI upper extremity 09/01/10

Referral note 09/07/10

Radiographic report 4 views right shoulder 10/23/10

Handwritten progress notes 11/18/10

Pre-authorization request 02/04/11

Postoperative shoulder physical therapy evaluation 02/10/11

Pre-authorization request 06/07/11

Pre-authorization request 06/08/11

Impairment rating exam 07/26/11

Peer review report 07/30/11

Report of medical evaluation 08/02/11

Request for peer review 08/04/11  
SOAP notes 10/28/11 and 11/18/11  
Right shoulder arthrogram and post-arthrogram MRI 11/16/11

Pre-authorization request 04/06/12  
Shoulder physical therapy evaluation 04/17/12  
Report of medical evaluation with impairment evaluation 04/18/12  
Pre-authorization request 05/06/12  
Procedures to be scheduled 07/13/12  
Utilization review determination 09/18/12  
Utilization review determination 09/21/12  
Pre-authorization request dated 09/27/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female whose date of injury is xx/xx/xx. Records indicate the claimant was stocking cases. She placed one and had a sharp pain on superior aspect of the right shoulder region. She took Advil and was able to complete her work that day. The following day she was helping to lift a patient up in bed with a draw sheet and had severe pain at the superior and anterior part of the shoulder. She took Advil, applied ice and went home that day with pain. She was treated conservatively with physical therapy and home/home exercise program. Claimant subsequently underwent right shoulder manipulation under anesthesia on 01/20/11 for adhesive capsulitis. The claimant indicated manipulation helped with regaining her motion, but she was still left with severe pain and muscle spasm. Claimant also was treated with corticosteroid injection which did not improve her symptoms. MRI arthrogram of the right shoulder on 11/16/11 revealed no evidence of deep partial or complete rotator cuff tear. There were findings consistent with subacromial/subdeltoid bursitis. No displaced labral tear was seen. The claimant was seen in follow up on 07/13/12 for right shoulder pain. Claimant states she regained her motion with physical therapy after manipulation, but still painful when she tries to raise her arm or reach behind her. Examination on that date revealed the claimant to be five feet tall and 242 pounds. Bilateral lower extremities and left upper extremity have non-painful range of motion. Upper extremity, right shoulder reveals tenderness over the AC joint. There's positive impingement signs and positive Speed test. AATE is 155 degrees with 175 degrees of discomfort past 125 degrees. Internal and external rotation's better than prior visit with discomfort at extreme; 4+/5 strength with drop arm test. Claimant was recommended to undergo right shoulder examination under anesthesia (EUA), diagnostic arthroscopy with debridement, subacromial decompression (SAD), Mumford procedure and rotator cuff repair (RCR).

The requested surgery was non-authorized per utilization review findings dated 09/18/12 noting that Official Disability Guidelines criteria for rotator cuff repair or surgery for impingement are not met. History of night pain is not documented. Positive response to diagnostic shoulder injection is not documented. Evidence of rotator cuff deficit per imaging is not documented.

A reconsideration request for outpatient right shoulder examination under anesthesia (EUA), diagnostic arthroscopy with debridement, subacromial decompression (SAD), Mumford procedure and rotator cuff repair (RCR) was non-authorized per utilization review findings dated 09/21/12. It was noted the documentation does not establish medical necessity for the requested surgery per referenced evidence based guidelines. History of night pain is not documented. Positive response to diagnostic shoulder injection is not documented. Evidence of rotator cuff deficit per imaging is not documented. Therefore the reviewer agreed with the original decision of non-authorization for the requested outpatient surgery.

**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 outpatient examination under anesthesia (EUA), diagnostic arthroscopy with debridement, subacromial decompression (SAD), Mumford procedure and rotator cuff repair (RCR) is not supported as medically necessary.

The claimant is noted to have sustained an injury on 07/29/10, with second injury the next day on 07/30/10. Claimant initially was treated with conservative measures, but developed adhesive capsulitis. She underwent manipulation under anesthesia on 01/20/11. Records indicate the claimant regained motion following manipulation, but continued with right shoulder pain when she tries to raise her arm or reach behind her. MRI arthrogram of the right shoulder revealed no evidence of partial or complete rotator cuff tear, and no displaced labral tear seen. Examination on 07/13/12 reported positive impingement signs and positive Speed test. Claimant had range of motion limitations, with discomfort past 125 degrees. There was no evidence of night pain. Records did not demonstrate that the claimant had undergone a diagnostic injection of the right shoulder with appropriate temporary relief following injection as recommended by the guidelines. As such, medical necessity is not established for the proposed surgical procedure.

**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)