

# True Decisions Inc.

An Independent Review Organization  
2002 Guadalupe St, Ste A PMB 315  
Austin, TX 78705  
Phone: (512) 879-6332  
Fax: (214) 594-8608  
Email: rm@truedecisions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Apr/01/2013

**IRO CASE #:**

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

Recon Right shoulder scope 29807

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

Orthopedic surgery

**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:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Osteopathic manipulation reports 11/16/12-11/30/12  
MRI right shoulder 12/14/12  
Clinical records 12/26/12 and 01/16/13  
MR arthrogram right shoulder 01/08/13  
Prior reviews 01/23/13 and 02/14/13  
Cover sheet

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who sustained an injury to the right shoulder on xxxxxx. It was unclear what the mechanism of injury was. The patient was initially provided osteopathic manipulation through 11/30/12. No significant improvement in the right shoulder pain was noted. MRI of the right shoulder on 12/14/12 revealed severe tendinosis of the infraspinatus tendon with low grade interstitial tearing of the subscapularis tendon. The supraspinatus tendon appeared intact. There was increased signal within the posterior superior labrum consistent with possible tearing. Mild degenerative changes of the acromioclavicular joint were noted and there was intermediate signal within the rotator cuff interval possibly representing scarring. The patient was seen on 12/26/12. The patient reported ongoing right shoulder pain. Physical examination revealed active range of motion to 40 degrees with passive range of motion to 50 degrees. There was tenderness over the subacromial joint and moderate reduction in right shoulder strength. recommended MR arthrography to evaluate the labrum. An MR arthrogram of the right shoulder on 01/08/13 identified a SLAP lesion of the labrum in the superior aspect. No apparent involvement of the biceps tendon anchor was noted. Physical examination on 01/16/13 again identified tenderness in the subacromial joint of the right shoulder and proximal humerus. There was mild weakness and limited range of

motion secondary to pain. The request for a right shoulder arthroscopy was denied by utilization review on 01/23/13 as there was limited documentation regarding physical therapy and no extensive tearing of the labrum to support the request. The request was again denied by utilization review on 02/14/13 as the findings for the labrum were not extensive and the patient only had a minimal amount of conservative treatment.

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

The patient has had ongoing complaints of right shoulder pain with significant loss of range of motion secondary to pain. Imaging studies revealed severe tendinopathy of the rotator cuff with scarring and labral tear. MR arthrography of the right shoulder did not identify any extensive type 2 or 4 tearing of the labrum and the patient has had only a minimal amount of conservative treatment including six documented sessions of therapy. Given the lack of any significant and given the lack of extensive conservative treatment and the minimal amount of tearing in the labrum, it is unclear how the requested surgery will reasonably improve the significant loss of range of motion in the right shoulder which does not appear to be due to the labral tear noted on arthrography. There is no evidence of significant instability. Overall, the patient does not meet guideline recommendations for the requested surgical procedure and in the opinion of this reviewer medical necessity is not established and the prior denial is upheld.

**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)