

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/20/2012

IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Left shoulder EUA/DX Arthroscopy w/debridement/SAD/Mumford/RCR/Slap repair

**A 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that the requested Left shoulder EUA/DX Arthroscopy w/debridement/SAD/Mumford/RCR/Slap repair is not medically necessary.

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

ODG - Official Disability Guidelines & Treatment Guidelines  
Request for IRO dated 11/30/12  
Receipt of request for IRO dated 12/03/12  
Utilization review determination dated 11/07/12  
Utilization review determination dated 11/20/12  
Clinical records dated 03/06/12, 03/13/12, 04/04/12, 04/18/12, 05/08/12, and 06/19/12  
MRI of the shoulder dated 04/26/12  
Clinical note dated 08/06/12, 08/27/12, and 10/12/12  
Radiographic report left shoulder dated 08/06/12  
Physical therapy treatment records various dates

**PATIENT CLINICAL HISTORY [SUMMARY]:** The claimant is a male who is reported to have suffered a shoulder dislocation on xx/xx/xx when he fell from a 4-wheeler. It is reported that he sustained an inferior dislocation with slight impaction of the superior portion of the left humeral head. An apparent attempt was made to reduce the dislocation. He was ultimately reduced in the emergency department. The claimant subsequently came under the care. Postoperatively, he was placed in a sling and was referred to physical therapy. Despite having undergone physical therapy, he is reported to have continued elevated levels of pain in his shoulder. The claimant was referred for MRI of the left shoulder on 04/26/12. This study notes a vertical linear tear in the superior labrum extending from anterior to posterior margins. There is no evidence of rotator cuff tear or tendinopathy; no signs of bony impingement. The acromion is type I. There is a 2-3 cm rounded signal abnormality in the anterolateral humeral head. There is a fracture line within this lesion, mainly involving the

greater tuberosity. On 05/08/12, the claimant was noted to be 9 weeks status post closed reduction. He is noted to have some improvement but continues to have some pain. He is continued on activities as tolerated and he was allowed to return to work with no restrictions. When seen in follow-up on 06/19/12, the claimant is noted to be 15 weeks status post closed reduction. He is noted to be progressing with his activities but continues to have pain in the left shoulder. On physical examination, he has full active range of motion in the shoulder with some tenderness with motion. The claimant was subsequently recommended to have a 2nd opinion regarding treatment of a SLAP tear. On 08/06/12, the claimant was seen. At this time, it is noted that the claimant continues to have left shoulder pain. He has completed physical therapy x10. He is noted to have interior AC pain and pain with overhead activities. On physical examination, he is noted to have mild deltoid atrophy. Forward flexion is to 90 degrees, passively to 130; elevation is to 130 degrees and abduction is to 130 degrees. Internal and external rotation are full. There is a mild Hawkins impingement sign, negative drop arm test, and equivocal O'Brien's test. The claimant was opined to have a SLAP tear with Hill-Sachs lesion, and AC arthritis. He subsequently was recommended to undergo surgical intervention to include arthroscopic debridement, Mumford procedure, Neer acromioplasty, and possible SLAP repair.

The claimant was seen in follow-up on 08/27/12. It is noted that the claimant was not approved for surgical intervention other than a EUA. The claimant's physical examination is grossly unchanged. then recommends surgical intervention.

The initial review was performed on 11/07/12. non-certifies the request noting that the Official Disability Guidelines recommend a Mumford procedure only after conservative care of at least 6 weeks with subjective complaints of pain at the AC joint and aggravation of pain with shoulder motion plus tenderness over the joint or pain relief by injection of anesthesia. He discusses the recommendations for treatment of acromioplasty. He subsequently opines that the request does not meet ODG criteria.

The appeal request was reviewed on 11/20/12. notes that the claimant has previously been denied surgical intervention as there is no documentation of corticosteroid injection with temporary relief. There is no documentation of nocturnal pain. He notes that x-rays do not show post-traumatic changes of the AC joint, severe degenerative disease of the AC joint, or an incomplete separating of the AC joint. He notes that there is no updated documentation submitted for review addressing the above reasons for non-certification. He notes that there continues to be a lack of information regarding functional response, modalities used, and patient compliance. He subsequently upholds the previous denial.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The submitted clinical records do not provide clear, objective data establishing that the claimant has failed all appropriate conservative management to include intraarticular injections and an aggressive home exercise program in conjunction with active physical therapy. No new clinical information was provided from the requester to support a recommendation to overturn the prior denials. As such it is the opinion of the reviewer that the requested Left shoulder EUA/DX Arthroscopy w/debridement/SAD/Mumford/RCR/Slap repair is not medically necessary.

**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)**