

# True Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Aug/28/2013

**IRO CASE #:**

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

Left Shoulder Arthroscopy, AC Joint Resection, Subacromial Decompression, Rotator Cuff Repair, Labral Repair

**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  
Request for IRO dated 08/07/13  
Receipt of request for IRO dated 08/08/13  
Utilization review determination dated 07/16/13  
Utilization review determination dated 08/07/13  
Clinical notes dated 07/26/10, 08/02/10, 08/18/10, 08/30/10, and 09/22/10  
Operative report for the right ankle dated 08/10/10  
MRI of the left shoulder dated 05/23/13  
Clinical note dated 05/29/13  
Clinical note dated 06/20/13  
Toxicology report dated 06/20/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who is reported to have sustained work related injuries to the right shoulder on xx/xx/xx. Records indicate that the claimant has a prior history of a bimalleolar fracture of the right ankle. He subsequently was taken to surgery on 08/10/10. Postoperatively, the claimant received postoperative physical therapy.

On 05/23/13, the claimant was referred for an MRI of the left shoulder. This study notes tendinosis and low grade intrasubstance tearing of the subscapularis tendon with no full thickness tear. He has a subtle irregularity of the anterior superior labrum suspicious for a

non-displaced labral tear. There are mild degenerative changes in the acromioclavicular joint.

On 05/29/13, the claimant was seen in follow up. He is noted to have no changes in his shoulder discomfort; not worsened or improved. He reports that he does not take his medications regularly and that he does not like taking meds.

The claimant was subsequently seen on 06/20/13. At this time, it is reported that the claimant was pushing a piece of pipe at work 2 months ago when he felt an instant onset of pain. It is suggested that he had a subluxation event with an anterior labral cartilage tear and partial thickness rotator cuff tear. further suggests that the claimant popped his acromioclavicular joint loose. On physical examination, he is noted to be 5 feet 6 inches tall and weighs 170 lbs. It is reported that the claimant has fairly significant subacromial impingement on plain films and an MRI. The claimant is noted to have tenderness to palpation of the anterior capsular structures through internal and external rotation. He had positive pain with crossed arm reach and positive labral signs. He was reported to be exquisitely tender over the acromioclavicular joint and in the thumb down position against resistance over the anterolateral supraspinatus tendon and the anterior capsular structure through internal and external rotation of the shoulder. It was reported that the claimant had two months of anti-inflammatories and home exercises with light duty type work without improvement and the claimant was subsequently recommended to undergo surgical intervention.

The initial review performed on 07/16/13, noted that the claimant had left shoulder pain and decreased range of motion with positive Neer and Hawkins signs and tenderness to palpation over the anterior capsular structures. He further had possible labral and positive labral signs and was exquisitely tender over the acromioclavicular joint and the reviewer noted that the information submitted failed to meet evidence based guidelines for the requested service and that the Official Disability Guidelines reported failure of conservative treatment must be between three and six months and he further found that there was no documentation indicating that the claimant had participated in any form of physical therapy. He subsequently found that the claimant did not meet criteria per Official Disability Guidelines.

The appeal request was reviewed on 08/07/13. The reviewer noted the prior non-certification and concurred with the prior reviewer noting that there was a lack of documentation regarding physical therapy and limited evidence supporting the presence of either type 2 or 4 SLAP lesion. He subsequently upheld the prior denial.

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

The submitted clinical records indicate the claimant is a male who sustained injury to his shoulder. The claimant underwent MRI of the left shoulder on 05/23/13 and was found to have tendinosis and a low grade intrasubstance tear of the subscapularis tendon, a subtle irregularity of the anterosuperior labrum suspicious for non-displaced labral tear and mild degenerative disease of the acromioclavicular joint. Treatment to date has included oral medications, activity modification and home exercises. The record does not contain any data suggesting that the claimant has received intraarticular injections of corticosteroids or formalized physical therapy as required by the Official Disability Guidelines. As such the claimant would not meet criteria per these guidelines and therefore the prior utilization review determinations are 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)