

Notice of Independent Review Decision

**DATE OF REVIEW:** 04/04/2008

**IRO CASE #:**

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

Right shoulder scope extensive debridement, Mumford procedure, acromioplasty, tissue graft patch autologous platelet concentrate tissue graft, and open rotator cuff repair.

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

**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 or not medical necessity exists for each of the health care services in dispute.

It is determined that the right shoulder scope extensive debridement, Mumford procedure, acromioplasty, tissue graft patch autologous platelet concentrate tissue graft, and open rotator cuff repair are not medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Chart Note from Dr. – 03/12/08
- Notice of Assignment of Independent Review Organization – 03/26/08
- Decision letter from – 01/17/08, 03/05/08
- Request for precertification from Dr. – 01/10/08, 02/27/08
- Initial evaluation by Dr. – 01/02/08
- Report of MRI of the right shoulder – 07/19/07
- Authorization request for physical therapy – 08/22/07
- Consultation by Dr. – 08/17/07
- Prescription for physical therapy – 08/17/07
- History and Physical from Medical Center by Dr – 06/13/07
- Emergency department record from Medical Center – 06/13/07
- Report of venous Doppler Study - 06/13/07
- Report of left lower extremity venous duplex scan – 06/13/07
- Physician's Progress notes from Medical Center – 06/13/07 to 06/15/07
- Utilization Review Form Medical Center – 06/15/07
- Information from TDI requesting review by an IRO – 03/26/08

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when he was driving a truck and was struck by another vehicle causing him to be thrown to the right of the cab and jamming his shoulder vertically. This resulted in injury to his right shoulder and left knee. The patient has been assessed for a traumatic tear right shoulder rotator cuff with associated 3 to 4 mm retraction and chronic traumatic impingement. He has been treated with medications, chiropractic care and physical therapy.

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

The arthroscopy debridement and acromioplasty could be considered to be medically necessary if they were requested independently of the requested additional surgical procedures which cannot be approved. As this preauthorization request is currently structured, complete approval cannot be justified. The use of autologous tissue graft patch and autologous platelet concentrate would be considered controversial and not justified. The partial tear described in the MRI performed on 07/19/07 does not justify approval of an open repair.

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

- ACOEM- AMERICAN 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)**