

Notice of Independent Review Decision

DATE OF REVIEW: 12/30/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder arthroscopic debridement with rotator cuff re-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 arthroscopic debridement with rotator cuff re-repair is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for obtaining a review by an IRO – 12/16/08
- Letter of determination from – 12/04/08, 12/15/08
- Report of MRI of the right shoulder – 04/03/08, 06/09/08
- Operative Report for Arthroscopy – 12/06/07
- Office visit notes by Dr. – 12/17/07 to 11/21/08
- Copy of OTG Guidelines for Shoulder – no date

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx resulting in injury to his right shoulder. An MRI of the right shoulder revealed evidence of a near full thickness rotator cuff tear with AC joint pain and proximal biceps tendon pain. The patient has undergone an arthroscopy of the right shoulder with debridement, decompression distal clavicle resection and repair of rotator cuff repair.

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

The patient is a xx year old male s/p arthroscopic debridement, RCR, SAD and distal clavicle resection of the right shoulder 12/2007. The patient is suffering recurrence of pain symptoms. MRI 6/2008 has been interpreted as revealing no tear. Supraspinatus tendonopathy has been diagnosed. No specific additional treatment has been provided other than NSAIDS and activity modification. Request for preauthorization repeat arthroscopy and repeat RCR denied; reconsideration denied.

There has been inadequate non operative treatment to justify arthroscopy of this patient's right shoulder pain. The diagnosis is not clear and could be tendonitis Rt supraspinatus. Medication and physical therapy could provide symptomatic relief given sufficient time. Previous denials of this request appear to have been appropriate. The denials appear to have been based on appropriate application of passages in ODG and current standards of care. The previous denials should be upheld.

**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)