

DATE OF REVIEW: 06/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder acromioplasty, rotator cuff repair, outpatient 23410

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 acromioplasty, rotator cuff repair, outpatient 23410 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 06/01/09
- Notification of Adverse Determination– 04/09/09, 05/07/09
- Request for preauthorization – 04/06/09
- History and Physical– 02/11/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx-xx-xx when he fell off of stairs resulting in pain to his right shoulder, left wrist, and left ribs. X-rays performed on 07/13/08 revealed a non-displaced fracture surgical neck right humerus and a left distal radius fracture. The patient suffers persistent pain and diminished range of motion of the right shoulder.

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

The only medical record documentation offered to substantiate the necessity for this request is an evaluation performed on 02/11/09. There is no documentation of physical therapy treatment. An MRI performed on 10/28/09 reportedly reveals a partial rotator tear and a possible glenoid labrum lesion. The medical necessity for the right shoulder acromioplasty and rotator cuff repair have not been established based on the ODG, 2009 shoulder chapter, related to arthroscopy for impingement syndrome, SLAP lesion and rotator cuff 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)**