

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 09/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthrotomy arthroscopy of the left shoulder, A/C joint arthroplasty acromioplasty repair tendonitis left tendon rotator cuff.

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 arthrotomy arthroscopy of the left shoulder, A/C joint arthroplasty acromioplasty repair tendonitis left tendon rotator cuff are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 08/31/09
- Adverse Determination Letter from – 07/20/09, 08/24/09
- Notice of Disputed Issue(s) and Refusal To Pay Benefits from – 01/15/09, 03/01/09
- Designated Doctor Evaluation by Dr. – 03/20/09
- Report of MRI of the left shoulder – 03/30/09
- Initial orthopedic consultation by Dr. – 05/07/09
- Worker's Compensation Initial Evaluation Report by Dr. – 01/06/09
- Pre-authorization request – no date
- Request for Reconsideration from Dr. – no date
- PEER Review by Dr. – 03/10/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was moving a piece of furniture in the bucket of a bobcat and was thrown from the vehicle. This caused injury to his back and left shoulder. The patient complains of low back pain associated with pain and tingling into the left posterior thigh and into the left posterior leg, neck pain, left shoulder pain and left bicep pain with tingling down the arm to the hand and fingers. The orthopedic surgeon has evaluated the patient for his left shoulder and neck and is recommending that the patient undergo arthrotomy arthroscopy of the left shoulder A/C joint arthroplasty acromioplasty repair tendinosis left tendon rotator cuff.

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

There is no documentation of non-operative treatment of this patient's symptoms. There is no documentation of a physical therapy program or treatment that has a high likelihood in relieving such symptoms. The ODG, 2009, shoulder chapter, surgery for impingement syndrome passage, requires documentation of non-operative treatment prior to the approval of a request to perform an arthroscopic subacromial decompression.

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)