

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 03/30/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder arthroscopy, possible rotator cuff repair with orthobiological graft with CPT codes 29823, 23912, 15430

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 arthroscopy, possible rotator cuff repair with orthobiological graft with CPT codes 29823, 23912, 15430 is medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 03/08/10
- Letter of determination– 01/11/10, 02/28/10, 02/01/10
- Letter– 03/09/10
- Results of review– 01/11/10, 02/01/10
- Request for preauthorization – no date
- Initial orthopaedic consultation by Dr.– 12/22/09
- Report of MRI of the right shoulder – 09/15/08
- Subsequent medical report by Dr.– 01/25/10
- Report of Medical Evaluation by Dr. – 11/02/09

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when he was pushing a wheelbarrow and felt a tearing sensation in the right shoulder. He had surgery in October of 2007. He sustained another injury on xx/xx/xx when a fire hydrant cap struck him in the clavicle resulting in a fractured clavicle, cervical strain and sprain, disc displacement and shoulder strain. He has been treated with physical therapy and chronic pain management.

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

This patient continues to demonstrate constriction and pain to the right shoulder. An MRI report from 09/15/08 is non-diagnostic secondary to a metallic artifact. A diagnostic/therapeutic surgical endeavor is appropriate in this case to fully delineate the injury and provide for care of the injury.

**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)