

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 11/05/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

R Shoulder Acromioplasty, Distal Clavicle Resection & 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 R Shoulder Acromioplasty, Distal Clavicle Resection & Rotator Cuff Repair 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 – 10/25/10
- Notification of Determination – 09/07/10, 10/04/10

- Preauthorization Request from Dr. – no date
- Request for Reconsideration from Dr. – 08/31/10
- Return patient visit notes by Dr. – 09/01/09 to 10/05/10
- Office visit notes by Dr. – 01/12/09 to 04/13/10
- Results of MRI of the right shoulder – 03/30/10
- Results of x-rays of the right shoulder – 02/15/10
- Results of x-rays of the cervical spine – 08/19/09
- Results of the Neurological Electro-Diagnostic Exam – 09/17/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx resulting in pain and injury to the cervical spine and right shoulder. The patient has been treated with steroid injections, physical therapy and surgery to include an anterior cervical discectomy fusion at C4-5 and C5-6. The treating physician has assessed the patient to have right shoulder pain with tenosynovitis, joint effusion and GLAD tear. The patient complains of paresthesias of the right upper extremity and myofascial pain of the cervical spine and right trap region. The treating surgeon has recommended that the patient undergo right shoulder acromioplasty, distal clavicle resection and rotator cuff repair.

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

There is no evidence presented in the medical record documentation that substantiates a torn rotator cuff. There does appear to be indication for arthroscopic shaping of the underside of the acromion, clearing of the A-C spurs and debriding of the subacromial bursa in a patient such as this when the injection helped him. However, the request as stated is not medically indicated when the rotator cuff is not torn.

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)