

Notice of Independent Review Decision

DATE OF REVIEW: 09/17/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient right shoulder arthroscopic synovectomy, complete; gleohumeral debridement and subacromial decompression

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 outpatient right shoulder arthroscopic synovectomy, complete; gleohumeral debridement and subacromial decompression are medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Notice of utilization review findings from – 08/05/10, 08/11/10
- Letter to TMF via Fax from – 09/09/10
- Retrospective medical record review by Dr.– 06/18/10
- Consultation by Dr.– 06/22/10
- Office visits notes by Dr.– 07/06/10 to 07/27/10
- Retrospective medical record review by Dr.– 07/21/10
- Pre-Authorization Request from Dr.– no date
- Orthopedic History and Physical by Dr.– 06/14/10
- Shoulder radiology conference by Dr.– 07/01/10
- Report of MRI of the right shoulder – 06/11/10
- Letter from Dr.– 08/03/10

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he slipped and fell backwards landing on his outstretched right shoulder. This resulted in immediate pain in his right shoulder and difficulty lifting his arm. The orthopedic surgeon's impression following a review of the MRI was complex fluid consistent with PVNS and massive irreparable rotator cuff tear, right shoulder. The patient has been treated with medications and physical therapy and the surgeon is now recommending that the patient undergo surgical repair.

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

There is documented pathology in this patient's right shoulder. The medical record documentation describes conditions that all have surgical indications. Therefore, it is determined that the outpatient right shoulder arthroscopic synovectomy, complete; gleohumeral debridement and subacromial decompression are medically necessary to treat this patient's condition.

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 KNOWLEDGBASE
- 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)