

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 03/15/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient left shoulder rotator cuff repair 23420

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 left shoulder rotator cuff repair 23420 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 – 03/01/11
- Decision letter– 01/27/11, 02/22/11

- Letter– 03/02/11
- Report of MRI of the right shoulder – 09/24/10
- Report of MRI with MR arthrogram left shoulder – 01/17/11
- Letter from Dr.– 02/02/11
- Chart notes by Dr.– 10/01/10 to 01/19/11
- Copy of ODG-TWC, ODG Treatment, Integrated Treatment/Disability Duration Guidelines, Shoulder (Acute & Chronic) – 02/17/11
- Interpretation of x-rays– 10/01/10, 10/25/10, 11/24/10, 12/29/10,
- History and Physical– 10/01/10
- Occupational Medical Care Patient Face Sheet – 09/22/10
- Employer's first report of injury – xx/xx/xx
- Office visit note– 09/16/10

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured work suffered a work related injury when he tripped and fell sustaining an injury to the shoulder. This resulted in a comminuted undisplaced fracture of the greater tuberosity of the left humerus. Healing of the fracture is in progress. The current diagnosis being offered by the provider is “complete rupture of the rotator cuff”. The patient is suffering persistent pain, has tenderness in the region of the greater tuberosity and diminished range of motion is evident. An MRI arthrogram performed 01/17/11 revealed no evidence of rotator cuff tear. The treating physician has recommended that the patient undergo a left shoulder rotator cuff repair.

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

Plain x-rays of the patient's shoulder dated 09/16/10 reveal an undisplaced fracture of the greater tuberosity of the left humerus. An MRI scan of the left shoulder dated 09/24/10 confirms that the injury is an undisplaced fracture of the greater tuberosity of the left shoulder. It would appear from the information included in the medical record that the patient has been treated with a sling and NSAID medication. No physical therapy treatment or local injection is documented. The criteria published in the ODG, 2011, shoulder chapter have not been met and there is insufficient documentation of non-operative treatment to indicate the medical necessity for the surgical procedure.

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)