

Notice of Independent Review Decision

**DATE OF REVIEW: 02/20/2012**

**IRO CASE #: 39456**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Right shoulder scope debridement vs bicep tenodesis 23430 29822 29807 29827

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

The TMF physician reviewer is board certified in orthopedic surgery 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 scope debridement vs bicep tenodesis 23430 29822 29807 29827 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 – 02/08/12
- Notification of Adverse Determination from – 12/22/11
- Notification of Reconsideration Determination – 01/30/12
- Letter from – 01/09/12
- Office visit notes by – 10/17/11 to 11/14/11
- Report of x-rays of the right shoulder – 10/17/11
- Report of Sensory Nerve Conduction Study – 11/09/11
- Patient Charting Note by – 09/13/11

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury on xx/xx/xx when he had a significant downward traction-type injury to the right arm. He describes the pain as a burning type pain and he has problems with lifting and/or reaching with the shoulder. The patient is being treated with medications and there is a request for a right shoulder scope debridement vs bicep tenodesis 23430 29822 29807 29827.

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

This patient suffered a traction type injury to the right shoulder and suffers persistent pain and diminished range of motion (ROM). The extent and methods of non-operative treatment have not been documented. Specific ROM measurements have not been recently documented. The current request for the surgical procedure as requested would not be medically indicated. There is insufficient documentation of non-operative treatment to conclude that such treatment has failed to provide benefit.

**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)**