

Notice of Independent Review Decision

DATE OF REVIEW: 10/15/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder subacromial decompression, coplane 29826, 29824

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 left shoulder subacromial decompression, coplane 29826, 29824 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 – 10/07/13
- Letter of adverse determination – 09/16/13, 09/30/13
- Utilization Review Worksheet – 09/11/13
- Report of peer to peer review – 09/16/13
- Surgery Preauthorization Request – 09/19/13
- SOAP notes – 06/25/13 to 09/11/13

- Report of shoulder subacromial inj w/ultrasound – 07/23/13
- Report of MRI of the left shoulder – 03/06/13
- Report of arthrogram shoulder – 03/06/13
- Report of MR of the left shoulder – 02/04/13
- Peer Report – 07/15/13
- Orthopedic Review – no date

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx resulting in a left shoulder straining injury. The patient suffers from persistent pain in spite of treatment with physical therapy, medications and subacromial and biceps tendon local injection. An MRI scan of the left shoulder revealed an interstitial substance tear of the subscapularis tendon and mild acromioclavicular joint degenerative joint disease. An arthrogram of the left shoulder did not reveal full thickness tear. The range of motion of the left shoulder has remained near full with complaints of discomfort. The current request is for subacromial decompression and distal clavicle resection.

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

The localization of pain generator is not well documented. There is no documentation of injection into the acromioclavicular joint. The effect of the subacromial and biceps tendon injection was not well documented. It appears that the patient may have received two days of symptomatic improvement without additional benefit. This patient has not met criteria for the requested arthroscopic subacromial decompression and distal clavicle resection of the left shoulder. Medical necessity for such a surgical procedure has not been met.

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)