

Notice of Independent Review Decision

DATE OF REVIEW: 02/10/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1. 29822 Arthroscopy shoulder surg; debrid, limited
2. 29826 Decompression of subacromial space

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 29822, arthroscopy shoulder surg; debrid, limited and 29826 decompression of subacromial space are not medically indicated to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information requesting a review by an IRO – 01/28/14
- Adverse determination letter – 11/20/13, 01/16/14
- Notice of Assignment To Independent Review Organization – 01/28/14
- Pre-Authorization Request Form – no date

- Request for peer to peer appeal of denial of services – 01/15/14
- Request for appeal – 12/16/13
- Progress notes – 10/08/12 to 12/12/13
- Medication list – no date
- Report of CT scan of the left shoulder – 02/08/13
- Report of the MRI of the left shoulder – 05/09/12
- Report of medical record review – 11/26/13
- Patient Evaluations – 05/02/12 to 02/12/13
- Report of radiographic studies – 05/02/12

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx. She suffered a small undisplaced distal clavicle fracture which has healed. She has been treated with NSAID medication, physical therapy and activity modification. She is tender over the AC joint. The request to preauthorize arthroscopic debridement of the left shoulder and acromioclavicular joint has been considered and reconsidered.

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

Applicable passages from the ODG, 2013, shoulder chapter have been reviewed. It is determined that the criteria required to be met to provide preauthorization of left shoulder arthroscopic debridement and debridement of the acromioclavular joint have not been met. Prior denials of this surgical preauthorization request were appropriate and should be upheld.

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)