

US Resolutions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

Notice of Amended Independent Review Decision

January 8, 2009

Amended February 3, 2009

DATE OF REVIEW: JANUARY 3, 2009

AMENDED February 3, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT Scan / Right Shoulder to Include 3-D Reconstruction Images and Aspiration of the Shoulder Fluid to be sent out to Laboratory for Cultures 73040

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

MD, Board Certified Orthopedic Surgeon

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.

The reviewer finds that medical necessity exists for CT Scan / Right Shoulder to Include 3-D Reconstruction Images and Aspiration of the Shoulder Fluid to be sent out to Laboratory for Cultures 73040.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, undated

ODG Guidelines and Treatment Guidelines

Letter from patient's lawyer, 12/2/08

MD, 6/25/08 (amended 8/13/08); 6/26/08 (amended 8/13/08); 7/24/08, 8/12/08, 9/16/08, 10/23/08, 11/19/08

Dr. MD, 8/15/08

XRay, 8/13/08

MD, 8/29/08
Designated Doctor Examination, 10/18/08
MD, 11/3/08, 10/16/08
Healthcare System ER Records, 4/5/07
Hospital Records, 4/23/07-4/26/07
MD, 12/6/06
PA-C, 3/19/07
MD, 7/17/07
Radiology Report, 8/10/07
Operative Report, 1/8/08
Follow-up Visit, 2/14/08
FCE, 6/25/08
Mental Health Evaluation, 6/26/08
Physical Therapy Records, 6/26/08-8/12/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker is a male. He has a previous history of a significant rotator cuff injury in the xxxx following which he had a rotator cuff repair. He was reinjured in xx/xxxx and underwent hemiarthroplasty, never fully recovered, and developed intractable pain. X-rays apparently show a hemiarthroplasty with rotator cuff arthropathy. Consideration is being made for a muscle transfer and/or a reverse hemiarthroplasty. The providing doctor's rationale for CT scan is to ensure there is adequate stock for the requested reverse arthroplasty and to evaluate him also by aspiration of the shoulder to ensure there is no underlying infection.

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

Based upon the history and physical findings and the medical records provided, the reviewer finds that medical necessity exists to aspirate this gentleman's shoulder to obtain culture to ensure there is no low-grade infection that would complicate a revision surgery. The reviewer finds that it is also medically necessary to ensure, with the type of procedure envisioned, that there is adequate bone stock to support the type of arthroplasty being proposed. It is for this reason that the medical records in this reviewer's opinion do substantiate the medical necessity of a requested CT scan with 3-dimensional reconstruction and the intraarticular aspiration and culture request.

The reviewer finds that medical necessity exists for CT Scan / Right Shoulder to Include 3-D Reconstruction Images and Aspiration of the Shoulder Fluid to be sent out to Laboratory for Cultures 73040.

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
- AHCPH- 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)