

SENT VIA EMAIL OR FAX ON  
Jul/14/2009

## Independent Resolutions Inc.

An Independent Review Organization  
835 E. Lamar Blvd. #394  
Arlington, TX 76011  
Phone: (817) 349-6420  
Fax: (817) 549-0311  
Email: rm@independentresolutions.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/09/2009

**IRO CASE #:**

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

Right Rotator Cuff Repair (arthroscopy, repair of rotator cuff, acromioplasty)

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

Doctor of Medicine (M.D.)  
Board Certified in Orthopaedic Surgery  
Fellowship Training in Upper Extremities

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines  
Denial Letters 6/1/09 and 6/11/09  
MRI 5/19/09  
US Med Group/ 5/12/09 thru 6/9/09

**PATIENT CLINICAL HISTORY SUMMARY**

The patient injured his shoulder at work. An MRI was obtained and it showed 25-50% tearing of the distal supraspinatus. A SLAP lesion was noted as well. Surgery was recommended. The patient is xx years old. No conservative care is documented.

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

The submitted medical records do not provide any rationale for why conservative care would not be appropriate in this patient. In addition, a diagnostic lidocaine injection has not been performed to see if the patient has functional weakness from the partial rotator cuff tear. Based on the submitted documentation, the requested procedures are not currently medically reasonable or necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)