

US Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW:

May/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left shoulder subacromial decompression, possible rotator cuff repair with biceps tenodesis and labral repair (23430, 29822, 23410, 23420, 29807, 29827, 29826)

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

M.D., board certified in Orthopedic Surgery

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

ODG Guidelines and Treatment Guidelines

Determination Letters, 3/11/09, 4/15/09

MRI Left Shoulder, 1/2/09

MD, 4/20/09, 2/23/09, 1/7/09, 3/20/09

DO, 1/6/09, 12/30/08

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who was injured in his employment on xx-xx-xx. He was lifting, resulting in the current injury. He has undergone physical therapy without improvement. The previous reviewer denied this for extent of injury. The reviewer was unable to locate in the medical records any documentation of nonsteroidal anti-inflammatories or injection of cortisone into the shoulder. Current request is for Left shoulder subacromial decompression, possible rotator cuff repair with biceps tenodesis and labral repair (23430, 29822, 23410, 23420, 29807, 29827, 29826).

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

This reviewer was unable to overturn the previous adverse determination for the following reasons: The ODG Guidelines which are statutorily mandated in the state of Texas do require either that the criteria be satisfied or an adequate explanation be provided to the IRO reviewer to permit the reviewer to understand why exception to the Guidelines should be made. In this case, the records provided do not show the patient has had an injection of cortisone into the shoulder and was not provided a course of a nonsteroidal anti-inflammatory, both of which are required to satisfy the ODG Guidelines. The treating

physician has also not provided in the records for this review an explanation as to why these were not performed. No explanation has been provided for why these particular treatments should be bypassed and the Guidelines set aside. It is for this reason that this reviewer was unable to overturn the previous adverse determination as to medical necessity. The reviewer finds that medical necessity does not exist at this time for Left shoulder subacromial decompression, possible rotator cuff repair with biceps tenodesis and labral repair (23430, 29822, 23410, 23420, 29807, 29827, 29826).

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)