

SENT VIA EMAIL OR FAX ON  
Sep/23/2009

## Independent Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/23/2009

**IRO CASE #:**

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

Right Shoulder Arthroscopy, Limited Debridement, Manipulation under Anesthesia, subacromial decompression, and Distal Claviclectomy

**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 7=24=09 and 8/13/09  
MRI 2/24/09  
Dr. 5/7/09 thru 8/3/09  
7/22/09 and 8/13/09  
Dr. 3/11/09 thru 8/27/09  
PPE 7/9/09  
MR Cervical Spine 2/24/09  
Diagnostics 3/30/09

**PATIENT CLINICAL HISTORY SUMMARY**

The patient complains of right shoulder pain and stiffness. MRI shows tendinosis and mild

AC joint arthropathy. ROM is limited. A subacromial injection gave limited relief. The patient has C6 radiculopathy and carpal tunnel syndrome on the right. The records do not address these findings. The patient has not responded well to physical therapy directed toward the shoulder and in some cases reportedly made the patient worse.

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

The request for shoulder surgery may be indicated at a future date; however, the cervical root compression and carpal tunnel syndrome may be contributing to the patient's problems and need to be addressed or at least discussed so that a clear treatment protocol and rationale is in order. Without such, the request is not 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)