

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/23/2010

**IRO CASE #:**

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

Left Shoulder Mini Open Rotator Cuff Repair Arthroscopic Subacromial Decompression  
Debridement and Synovectomy 29827 29826 29823 29821

**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

**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, Indications for Surgery, Rotator Cuff Repair  
Denial Letters, 5/6/10, 6/10/10  
7/8/10, 5/18/10, 6/30/10, 6/9/10, 5/25/10, 5/18/10  
Orthopedic Consultants 6/14/10  
Medical Clinic 6/7/09 to 12/17/09  
Orthopaedics and Sports Medicine 9/21/09, 9/8/09,  
8/13/09, 9/1/09  
M.D. 1/14/10, 4/29/10, 6/3/10  
Imaging 7/14/09  
Medicine Orthopaedic Group 9/14/09  
M.D. 5/5/10  
Medical & Surgical Association 4/28/10  
DO 6/8/10

**PATIENT CLINICAL HISTORY SUMMARY**

The patient has had 2 previous rotator cuff repairs. The patient reinjured his shoulder at work and has failed conservative management for continued painful shoulder range of motion and weakness. An MR arthrogram showed a small area of full thickness lesion of the distal supraspinatus. Previous request for surgery was denied because the reviewer did not have a copy of the arthrogram report.

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

The patient suffered an on the job injury and has continued pain in the shoulder. MR arthrogram confirms a full-thickness lesion of the supraspinatus. Based on this, the request for surgery is medically necessary at this point. The request meets the ODG criteria for surgical repair of a rotator cuff tear. The reviewer finds that medical necessity exists in this case for Left Shoulder Mini Open Rotator Cuff Repair Arthroscopic Subacromial Decompression Debridement and Synovectomy 29827 29826 29823 29821.

**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)