SENT VIA EMAIL OR FAX ON
Jan/13/2010

Applied Assessments LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Jan/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
OP Rt Shoulder Arthroscopy w/ rtc repair, sad, debridement

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

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 11/2/09 and 11/11/09
Dr. 10/30/07 thru 10/16/09
Insight 2/16/09 and 2/17/09
FRH 6/26/08
MRI 7/23/07
Ultrasound 11/9/07
xxxxxx 9/23/07

PATIENT CLINICAL HISTORY SUMMARY
The patient has undergone previous shoulder arthroscopy with rotator cuff debridement. This was not successful and he underwent an arthroscopic rotator cuff repair. He has persistent symptoms and is seeing another orthopedic surgeon. This other surgeon is recommending repeat shoulder arthroscopy. He feels that one of the rotator cuff anchors have pulled out and is floating in the subacromial space. He also feels that the patient may have a recurrent rotator cuff tear. A previous CT arthrogram performed this year shows no evidence of recurrent tear and no evidence of suture anchor pullout.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
The request for repeat shoulder arthroscopy is not medically reasonable or necessary based

on the records provided. The requesting surgeon has seen the patient one time and is assuming that all of his symptoms are related to this anchor. There is no imaging evidence of anchor pullout or repeat rotator cuff repair on the previously performed CT arthrogram. Without further clinical documentation of this or a subacromial lidocaine injection to confirm the diagnosis, the requested surgery which would be the patient's third shoulder surgery does not appear to be medically reasonable or necessary at this time.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)