

I-Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right shoulder arthroscopy, ASAD, DCE, RTC repair & indicated procedures-29826, 29824, 29827

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

M.D., Board Certified Orthopedic Surgeon

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

Official Disability Guidelines

, 8/17/10, 8/24/10

8/17/10, 8/24/10

Texas Orthopaedic 5/11/10 to 7/28/10

Imaging Center 4/29/10

7/7/10

PATIENT CLINICAL HISTORY SUMMARY

This is a female who injured her shoulder on xx/xx/xx. She was seen on 05/11/10 by the requesting surgeon, complaining of shoulder pain as well as neck and radiating type pain. It would appear that the patient has not had conservative care, although physical therapy is mentioned. It does appear she has not had an injection into the shoulder. It was noted from the MRI scan that there was tendinosis with a partial thickness undersurface tear of the distal supraspinatus and no full thickness tear. Surgery has been recommended.

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

While this reviewer does indeed respect and agree with the opinion of the treating surgeon that the literature supports the outcome of more likely than not progression to complete tear when there is an 80% tear of the rotator cuff, the ODG criteria for shoulder surgery has not been satisfied in this case. This is because this patient has not had an ESI according to the records provided. It is for this reason that the previous adverse determination could not be overturned at this time. The reviewer finds that medical necessity does not exist at this time for Right shoulder arthroscopy, ASAD, DCE, RTC repair & indicated procedures-29826, 29824, 29827.

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)