

# US Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/15/2010

**IRO CASE #:**

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

First rib resection

**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, TOS

Radiology Report, 2/19/09

Health & Medical, 11/20/08

MRI Right Shoulder, 5/7/08

Cervical MRI, 5/27/10

Medical Centers, 6/3/10, 2/26/09

MD, 7/26/10

Notes, 7/1/09, 6/5/09, 4/10/09, 4/2/09, 7/2/10, 6/23/10, 5/8/09, 2/4/09

Denial Letter, 7/13/10

Denial Letter, 7/19/10

**PATIENT CLINICAL HISTORY SUMMARY**

According to Dr.'s notes in July 2010, this patient is a right hand dominant female who injured her shoulder when a box fell on top of her. She is diagnosed with right Thoracic Outlet Syndrome. A right interscalene diagnostic injection was given on 7/26/10 and post injection exam noted complete pain resolution. There is negative EMG/NCS and negative cervical MRI and failure to improve with conservative management. Dr. notes "the individual denying the surgery is not aware of the thoracic outlet compression literature which states there are four types of thoracic outlet syndrome."

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

Dr. has provided this reviewer with the necessary information to agree that the requested procedure is medically necessary. The patient is diagnosed with right Thoracic Outlet Syndrome. A right interscalene diagnostic injection was given on 7/26/10 and post injection exam noted complete pain resolution. It appears that the URA denials in the case were made prior to this injection. Dr. has provided the appropriate references in the medical literature and has carefully laid out the rationale for the procedure. Therefore, the reviewer agrees with the provider that there is medical necessity in this patient's case for First rib resection.

**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)