

SENT VIA EMAIL OR FAX ON
Dec/27/2010

Applied Resolutions LLC

An Independent Review Organization
1124 N Fielder Rd, #179
Arlington, TX 76012
Phone: (512) 772-1863
Fax: (512) 853-4329
Email: manager@applied-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Dec/24/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Video Arthroscopy, Subacromial Decompression, Possible Limited Open Rotator Cuff Repair, Right Shoulder

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 12/1/10 and 12/7/10
Bone and Joint 9/23/10 thru 11/22/10
MRIs 11/16/10
Photos No Date

PATIENT CLINICAL HISTORY SUMMARY

The patient injured his right shoulder at work after being attacked by 2 pit bull dogs. He received multiple lacerations to the leg and also injured his shoulder. The requesting surgeon of pain and an MRI scan of the shoulder and it showed a partial, intrasubstance tear of the infraspinatus and rotator cuff tendinopathy. In addition, a deformity in the anterior humeral head was noted. The request for surgery has been denied by the insurance company based

on the lateral conservative care and that the documentation does not discuss the potential for history of posterior dislocation. The physical examination does not document whether or not this patient has any posterior instability.

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

The insurance company denials or reasonable based on the lack of documentation. This patient has not received any conservative care based on the medical records provided. In addition, the requesting surgeon has not discussed or documented whether or not this patient has a component of instability. Therefore, the request is not medically 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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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