



Listed below are details of a Prior Authorization Request (PAR) that was submitted to request confirmation that the proposed treatment(s)/test(s) are based on a correct application of the Medical Treatment Guidelines. The claim administrator has denied all or part of the request; please carefully review all items.

To the claimant: For any treatment/test that was **Denied**, if Denial Category is **Administrative** or **Jurisdiction** you or your legal representative may request review by filing *Request for Assistance by Injured Worker* (Form RFA-1W) or *Request for Further Action by Legal Counsel* (Form RFA-1LC) respectively. These forms are available under the "Forms" section of the WCB's website: [www.wcb.ny.gov](http://www.wcb.ny.gov). If you do not have access to the internet, please call (877) 632-4996 or visit our nearest Customer Service Center to obtain a copy of the form.

**Note:** If present, a Level 2 Insurer Response supersedes a Level 1 Insurer Response.

**CLAIM INFORMATION**

WCB Case #	Date of Injury	Claim Admin Claim #
G3226187	03/05/2022	2022007827

**Patient Name** Sislema Muyulema, Luis

**Address** 42-15 81st Street, Apt 5S  
Elmhurst, NY 11373

**SSN** XXX-XX-7321

**DOB** 09/20/1986

**Gender** Male

**Employer Name** Central Avenue Auto Repair

**Address** 227 N Central Avenue  
Valley Stream, NY 11580

**Insurer Name** EMPLOYERS PREFERRED INSURANCE COMPANY

**Insurer ID** W076592

**Address** 10375 PROFESSIONAL CIRCLE  
RENO, NV 89521-4802

**Claim Admin Name** EMPLOYERS PREFERRED INSURANCE COMPANY

**Claim Admin ID** W076592

**Address** 10375 PROFESSIONAL CIRCLE  
RENO, NV 89521-4802

## HEALTH CARE PROVIDER INFORMATION

**Name** SINHA UPENDRA K

**Address** 57-23 141st Street

Flushing, NY 11355

**Type** Physician

**WCB Auth #** 138337-1

**NPI** 1063520336

## PRIOR AUTHORIZATION REQUEST DETAILS

1.	Body Part	MTG Reference Code and Description	CPT Code and Description
	Right Shoulder	Shoulder - D.6.f: Surgical/Operative - Operative Procedures - Impingement Syndrome	29805: Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)

## STATEMENT OF MEDICAL NECESSITY / SUPPORTING MEDICAL DOCUMENTATION

Supporting documentation was provided as a part of this request.

## PROVIDER'S ATTESTATION

By submission of this request for prior authorization, I certify that my statements are true and correct, and I do not have a substantially similar request pending.

**Provider Name** SINHA UPENDRA K

**Date** 07/30/2022

**LEVEL 1 INSURER RESPONSE**

1.	Authorization Requested	Insurer Response
	<b>Body Part</b> Right Shoulder <b>MTG Reference Code and Description</b> Shoulder - D.6.f: Surgical/Operative - Operative Procedures - Impingement Syndrome <b>CPT Code and Description</b> 29805: Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)	<b>Insurer Response</b> Deny <b>Denial Category</b> Administrative Reasons Related To Claim Status <b>Denial Reason</b> Claim or Body Part/Condition Disallowed <b>WCB Determination Date</b> <b>WCB Document ID #</b> <b>Rationale</b> Please see attached FROI-04 denial.

**Claim Apportioned** No

Supporting documentation was provided as a part of this request.

**Name of the Reviewer** Scott Whitlow

**Date** 08/01/2022

**Reviewer Title** Program Administrator