

# US Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/23/2011

**IRO CASE #:**

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

IF8100 muscle stimulator

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

M.D., Board Certified 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**

Official Disability Guidelines-Treatment in Worker's Compensation, Chapter: Shoulder

Utilization review determination dated 10/04/11, 11/03/11

Letter dated 10/20/11

Reference material regarding IF 8100 unit no date

Designated doctor evaluation dated 07/20/11

Prescription and letter/certificate of medical necessity dated 06/20/11, 05/08/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was lifting feed off a pallet and tore his right rotator cuff and right bicep. Designated doctor evaluation dated 07/20/11 indicates that the patient is status post repeat rotator cuff repair with decompression of subacromial space and biceps tendon tenodesis. Diagnosis is reported as right shoulder repeat rotator cuff tear with proximal biceps tendon subluxation/dislocation; and status post repeat rotator cuff repair, subacromial decompression and biceps tenodesis. The patient was determined to have reached MMI as of 07/20/11 with 5% whole person impairment. Letter dated 10/20/11 indicates that the patient has had a rotator cuff tear along with a repair back in 2008 as well as a re-injury to his shoulder with re-repair rotator cuff tear with biceps tenodesis back in September 2010. He has progressed slowly with therapy and still has tenderness over the upper back and scapula region. The patient feels that the stimulator unit provided significant symptomatic relief.

Initial request for IF 8100 muscle stimulator was non-certified on 10/04/11 noting that the medical report failed to provide a recent subjective and objective clinical evaluation with a detailed physical examination from the treating physician. Failure to respond to recommended conservative treatment such as oral pharmacotherapy or rehabilitation was not

objectively documented through VAS pain scales and PT progress reports. Furthermore, treatment plan including the specific short-term and long-term goals of treatment with the unit and specification of its use was not submitted for review. The denial was upheld on appeal dated 11/03/11 noting that there is no clear documentation of a recent comprehensive clinical evaluation of the patient from the provider or treating physician that addresses the proposed DME. There is no documentation provided with regard to the failure of the patient to respond to conservative measures such as evidence based exercise program and medication prior to the proposed purchase of IF8100 muscle stimulator. The patient underwent PT sessions; however, there were no updated therapy progress reports that objectively document the clinical and functional response of the patient from the completed sessions. The specifications for the use of the requested DME are not provided for review, which include the timing of use, frequency of use and duration of use.

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

The patient sustained injuries in xx/xx/xx; however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There are no operative reports, imaging studies, radiographic reports, or treatment records/physical therapy notes submitted for review. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals were provided. The patient has reportedly undergone a trial of the IF 8100 muscle stimulator; however, the patient's objective, functional response to the unit is not submitted for review to establish efficacy of treatment. Therefore, the reviewer finds no medical necessity at this time for IF8100 muscle stimulator.

**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)