

# IRO Express Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Dec/02/2013

### IRO CASE #:

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

Right Shoulder Rotator Cuff Repair and an Ultra Sling

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

Board Certified Orthopedic Surgeon (Joint)

### 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical note dated 08/14/13

MRI of the right shoulder dated 08/21/13

Clinical note dated 08/28/13

Clinical note dated 10/02/13

Adverse determinations dated 09/17/13 & 10/18/13

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his right shoulder from a work related injury. The clinical note dated 08/14/13 indicates the patient having a 1 ½ month history of right shoulder complaints. The patient stated that he felt a pull in his shoulder on xx/xx/xx. The patient was noted to have complaints of diffused pain at the shoulder. The patient described the pain as a throbbing, sharp, and severe pain that was rated as 4-8/10. Pain was also elicited with overhead activities. Radiating pain was noted. Night time pain was noted to be worse. Driving, bending, and moving all exacerbated the patient's pain. Upon exam, tenderness was noted at the anterior region of the right shoulder. The patient was noted to have normal range of motion throughout the right shoulder. The MRI of the right shoulder dated 08/21/13 revealed a distal supraspinatus tendon full thickness tear from the mid and anterior greater tuberosity insertion with moderate retraction. The clinical note dated 08/28/13 indicates the patient continuing with right shoulder pain that was rated as 4/10. Strength deficits were noted with abduction. The clinical note dated 10/02/13 indicates the patient continuing with pain with overhead activities. The patient was recommended for an

arthroscopic rotator cuff repair.

The previous utilization review resulted in a denial for a rotator cuff repair as a lack of documentation was submitted concerning conservative treatments.

The utilization review dated 10/18/13 resulted in a denial for a rotator cuff repair as documentation of significant functional deficits was not noted.

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

The documentation submitted for review elaborates the patient complaining of right shoulder pain with associated strength deficits. A rotator cuff repair is indicated provided the patient meets specific criteria to include imaging studies confirming the patient's significant pathology involving a full thickness tear. The MRI of the right shoulder revealed a full thickness tear of the distal supraspinatus along with moderate retraction. Given these findings as well as the confirmation by imaging studies, this request is reasonable. As such, this reviewer recommends a right shoulder rotator cuff repair with an ultrasling as 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)