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Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: X; Amendment X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

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

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned (Disagree)

☐ Partially Overtuned (Agree in part/Disagree in part)

☒ Upheld (Agree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. The biomechanics of the injury were not available in the provided records. The diagnoses were status post right shoulder revision rotator cuff repair and recurrent right shoulder massive rotator cuff tear (irreparable). X was seen by X, PA-C / X, MD on X for a follow-up of right shoulder. X was X months status post right shoulder revision rotator cuff repair. X recalled a specific incident in physical therapy where X felt a painful pop. They stopped in physical therapy sometimes in X after this incident. X had persistent pain and weakness. X stated even holding a coffee cup for short period of time hurt X shoulder. An MRI performed on X, showed a recurrent complete massive rotator cuff tear with significant retraction to the level of the glenoid. On examination, X had about X degrees of forward flexion and abduction. X had a painful arc of range of motion. X rotator cuff apprehension test was noted. Muscle strength was X in the rotator cuff. Dr. X discussed that this recurrent rotator cuff tear was irreparable and that X would require a X. X had persistent pain and weakness. The MRI showed a recurrent massive complete rotator cuff tear with significant retraction. X tear was irreparable. X stated X could not live with X shoulder like this and X certainly would not be able to perform X job. X wanted to proceed with X. X had a second opinion by Dr. X who agreed that X needed a X. The incident of painful pop occurred during physical therapy during X recovery, and therefore Dr. X opined that a X should be covered under workmen's compensation. Per an office note dated X by Dr. X, an MRI of the right shoulder dated X

revealed X. Moderate X was noted. There was evidence of an X. X along the undersurface of the X was noted. X was seen. Expected X appearance was noted. X was noted. There was X seen. There was X. A X was noted. X was seen. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied. Rationale: “The Official Disability Guidelines recommended X. On X, the claimant underwent X. Exam showed forward flexion/abduction X degrees, good internal/external rotation, good manual rotator cuff testing. There is no documentation of . As such, the request for is recommended non-certified. “Per a reconsideration utilization review adverse determination letter dated X, the request for X was denied. Rationale: “There is a request for X. The Official Disability Guidelines support this surgical procedure for those with a nonfunctioning irreparable rotator cuff tear if they have not been improving with at least X months of conservative care. The previous review did not certify this request as there had not been X months of conservative treatment at that time. However, although it is now X months since the date of that surgery, physical examination does not demonstrate a nonfunctioning rotator cuff. Progress notes near full range of motion and normal strength of the rotator cuff with continued improvement. Considering these examination findings there is unlikely to be any functional benefit with an X. This request for a X is not supported and is recommended for noncertification. “Per a utilization review adverse determination letter dated X, the request for X was denied. Rationale: “There is a request for X for this claimant. The Official Disability Guidelines support this surgical procedure for those with a nonfunctioning irreparable rotator cuff tear if they have not been improving with at least X months of conservative care. The previous review did not certify this request as there had not been X months of conservative treatment at that time. However, although it is now X months since the date of that surgery, physical examination does not demonstrate a nonfunctioning rotator cuff. Progress notes near full range of motion and normal strength of the

rotator cuff with continued improvement. Considering these examination findings, there is unlikely to be any functional benefit with an X. These concerns were expressed in the previous review. No additional information has been provided. The request for a X is noncertified. Because an adverse determination for surgery has been rendered, an adverse determination for any associated preoperative clearance is also rendered." The requested surgical procedure is not medically necessary. The clinical records including the physical examination does not demonstrate a nonfunctioning rotator cuff. Progress notes near full range of motion and normal strength of the rotator cuff with continued improvement. The clinical examination does not demonstrate a non-functioning rotator cuff or functional limitations whereby the requested procedure is indicated. No new information has been provided which would overturn the previous denials. X is not medically necessary and non certified.

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

The requested surgical procedure is not medically necessary. The clinical records including the physical examination does not demonstrate a nonfunctioning rotator cuff. Progress notes near full range of motion and normal strength of the rotator cuff with continued improvement. The clinical examination does not demonstrate a non-functioning rotator cuff or functional limitations whereby the requested procedure is indicated. No new information has been provided which would overturn the previous denials. X is not medically necessary and non certified.
Upheld

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**