



Physio
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**Notice of Independent
Review Decision**

Send to:

IRO Reviewer Report

X

IRO Case number: TX X

Description of the services in dispute

X

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** of the health care services in dispute.

Information provided to the IRO for review

X

Patient clinical history

X, date of birth X, is a X individual diagnosed with left shoulder pain and traumatic complete tear of the left rotator cuff; and seeking coverage for left shoulder arthroscopic rotator cuff repair, subacromial decompression, and biceps tenodesis. The claimant sustained an injury on X and reported pain in the left shoulder. The claimant had used X. The X left shoulder MRI report detailed a X. There was X. X was noted. There was X. X was noted. The X evaluation by X, MD, described the injury as the claimant X. The

evaluation noted X. There were X noted. The proposed X.

Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision

X is a X individual diagnosed with left shoulder pain and traumatic complete tear of the left rotator cuff; and seeking coverage for left shoulder arthroscopic rotator cuff repair, subacromial decompression, and biceps tenodesis.

In this case, the claimant presents with a X. The claimant has corresponding weakness on the current physical exam with painful and limited range of motion with a positive empty can sign. In this case, the current evidence-based guidelines such as ODG recommend X. It is unlikely that X. Further, for large full-thickness tears of the rotator cuff, X is commonly required and is supported by current evidence-based guidelines. Therefore, it is this reviewer's opinion that the medical necessity for the X requests is established, and the prior denials are overturned.

Description and source of the screening criteria or other clinical basis used to make the decision

ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase AHRQ - Agency for Healthcare Research and 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

ODG - Official Disability Guidelines & Treatment 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)