

# Applied Resolutions LLC

An Independent Review Organization

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## ***Notice of Independent Review Decision***

### **IRO REVIEWER REPORT**

**Date:** 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:

- |   |                                |
|---|--------------------------------|
| <input type="checkbox"/> Overturned           | Disagree                       |
| <input type="checkbox"/> Partially Overturned | Agree in part/Disagree in part |
| <input checked="" type="checkbox"/> Upheld    | Agree                          |

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

X

**PATIENT CLINICAL HISTORY [SUMMARY]:**

X is a X who sustained an injury on X. While working as a X. X went to X. X . The diagnosis included strain of muscles and tendons of the rotator cuff of left shoulder.

On X, X underwent left shoulder arthroscopic glenohumeral extensive debridement; arthroscopic glenohumeral complete synovectomy; subacromial decompression and bursectomy; and arthroscopic-assisted rotator cuff repair, performed by X, MD. The preoperative diagnoses were full-thickness rotator cuff tear and prior greater tuberosity fracture with persistent impingement. The postoperative diagnoses were a 2.5 cm full-thickness rotator cuff tear, impingement syndrome with greater tuberosity deformity, glenohumeral synovitis, and anterior and posterior labral fraying.

Per the physical therapy progress note dated X, X was seen by X for the X for the left shoulder. X was status post left shoulder surgery on X. X continued to have difficulty with lifting objects above head height and opening jars. On examination, X left upper extremity functional index score was X (on X it was X. The left shoulder range of motion was X degrees with flexion (prior X degrees), X degrees with abduction (prior X degrees), X degrees with extension (prior X degrees), X with functional external rotation reach (prior unchanged), X with functional internal rotation reach (prior X), X degrees with external rotation in neutral position (prior unchanged), and X degrees internal rotation in neutral position (prior unchanged). Left shoulder flexion and abduction strength was X and extension strength was X. The power grip was X psi. The plan was for X.

On X, X was evaluated by X, MD. X was making slow progress and had undergone X since the surgery. X stated X really had only started strengthening. Left shoulder passive range of motion revealed forward elevation X degrees and external rotation X degrees. There was mild weakness of abduction. X had good external rotation strength. The plan was for X due to possible cervical radiculopathy given loss of grip strength while having arm overhead.

Treatment to date included medications (X).

Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: "Notes from the referring agency indicate that the claimant has been approved for X to date. The X requested when considered with the X already approved exceeds the X recommended by ODG for treatment of the claimant's diagnosis. There are no clear extenuating circumstances indicating why a transition to a home exercise program is not yet possible. Based on the information available, the request is not shown to be supported by the aforementioned guidelines nor otherwise medically necessary. Therefore, the request for X is not medically necessary."

Per the appeal review by X, MD on X, the request for X was non-certified. Rationale: "Per Official Disability Guidelines, "Rotator cuff syndrome/Impingement syndrome: Post-surgical treatment, arthroscopic: X. Although the patient has ongoing limited range of motion and slightly limited motor strength, the patient has previously attended X to date. There is no indication the patient is unable to address remaining deficits in a X. Therefore, the request is not certified."

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

Based on review of the submitted medical documentation, the claimant has X of postoperative X following X. There is no indication the claimant is unable to X. The submitted records do not demonstrate significant deficiencies whereby a formal X program would be supported. Any remaining deficiencies should be addressed by a X. As such, the request for X is not medically necessary.

Upheld

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

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE