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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:

☒ Overturned Disagree

☐ Partially Overturned Agree in part/Disagree in part

☐ Upheld Agree

Pure Resolutions LLC

Notice of Independent Review Decision

Case Number: X Date of Notice: X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured at work on X. X was at work, doing a X. The ranch slipped. X felt a pop in X shoulder and had been having progressively worsening pain since that point. The diagnosis was unspecified rotator cuff tear / rupture of right shoulder, not specified as traumatic (X).

On X, X was evaluated by X, PA-C for ongoing complaints of right shoulder pain. At the time, X presented for repeat evaluation of X shoulder and MRI follow-up of the neck. X was a few months out from X. X was continuing to have shoulder pain. X stated X biggest complaint was pain with overhead motion. X stated X did have numbness and tingling, but this was not his biggest complaint. X complaint was about pain specifically in the shoulder with range of motion. On examination, X had active forward flexion approximately X degrees, active abduction about X degrees, and it was limited due to stiffness. They were going to work on getting more therapy approved and see X back in X weeks to see if X was making any improvement. On X, X was seen by X, MD for ongoing complaints of right shoulder pain. X had an MRI showing severe stenosis of the cervical spine. X also had surgery in X, which involved decompression as well as tenotomy of X shoulder. MRI since this shoulder surgery revealed X. No physical examination was documented. They discussed options and were going to proceed with a X followed by an open rotator cuff repair. This was a very complex issue. They talked about implications of cervical spine disease as well as timing of any intervention. X was eager to proceed with arthroscopy of X right

shoulder. This would be because of MRI done that month showing a X.

An MRI of the right shoulder done on X revealed a X. Mild partial thickness X was noted. A tear of the X was suspected. An MRI of the right shoulder on X revealed a X. A X was well-defined at the time. However, it was probably similar compared to the prior study. The mild partial X was seen. Arthritic changes of the X were present. A tear of the X was suspected.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Based on the provided documentation, the patient has upper back pain. A physical examination of the shoulder revealed that it was not taken. Per ODG guidelines, "Recommended as a treatment option; may be a first-line or second-line treatment option. " Per ODG guidelines, "Conditionally Recommended. " A Magnetic resonance imaging (MRI) of the right shoulder on X revealed a X. The X is well-defined today. However, it is probably similar compared to the prior study. Mild partial thickness X. Arthritic changes of the X. A tear of the X is suspected. The patient has upper back and right shoulder pain. However, there are limited positive objective findings of the right shoulder and failed non-operative treatments. Therefore, the request is not medically necessary. Therefore, the request for X is noncertified.”

On X, Dr. X wrote an appeal letter for reconsideration of denial of the request for X.

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Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale: "ODG by MCG Shoulder (Last review/update date: X) Diagnostic Arthroscopy for Shoulder Conditions Body system: Shoulder Treatment type: Diagnostic Testing, Surgery Recommended (generally)R Recommended only when a definitive shoulder diagnosis cannot be made with standard imaging and examination, following failure of X." The patient previously underwent a X on X, which did not demonstrate the presence of a X. The MRI scan on X is like the previous MRI scan on X. A detailed examination has not been provided by the treating provider. No rationale was provided for the X. There is no documentation of X. As such, the guidelines have not been met. Therefore, the request for X, is upheld."

The claimant had continued with ongoing right shoulder pain with the available MRI reports detailing X. The claimant's exam findings noted X. For a large full thickness tear of the rotator cuff, the current evidence-based guidelines would support proceeding with a X. There was X present on imaging. Therefore, it would be appropriate to proceed with X. Non-operative measures are not effective for addressing full thickness tearing of the rotator cuff. Therefore, it is this reviewer's opinion that medical necessity is established for the services in question and the prior denials are overturned. X is medically necessary and certified.

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

The claimant had continued with ongoing right shoulder pain with the available MRI reports detailing X. The claimant's exam findings noted X.

For a large full thickness tear of the rotator cuff, the current evidence-based guidelines would support proceeding with X. There was X present on imaging. Therefore, it would be appropriate to proceed with X. Non-operative measures are not effective for addressing full thickness tearing of the rotator cuff. Therefore, it is this reviewer's opinion that medical necessity is established for the services in question and the prior denials are overturned. X is medically necessary and certified.

Overturned

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

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☐ 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