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Notice of Independent Review Decision

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 Overturned Agree in part/Disagree in part
- Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X injured X left shoulder X. The diagnoses were pain in left shoulder (X), complete rotator cuff tear / rupture of left shoulder, superior glenoid labrum lesion of left shoulder, sprain of left rotator cuff capsule and bicipital tendinitis of left shoulder.

X was seen by X, MD on X for complaint of left shoulder pain. X had been treated with X. X was instructed on a X but that was painful and did not help X symptoms. X still had intermittent, X pain with any abduction or lifting. It was aching in character. X had weakness, which kept X from carrying objects with X left arm. X was on light duty at work. X had no X. Examination of the left shoulder showed X. It was opined that X likely had a X. X seemed to be torn more acutely in the X. Left shoulder open X were recommended. There was no further role for X at the point as X had a significant X. A X was not recommended as that would decrease the success of any future repairs.

A Designated Doctor Examination was completed on X by X, DC. X complained of left shoulder pain rated X and weakness in the arms. Examination revealed X. Motor strength was X in the left deltoid secondary to the pain. Apprehension test, impingement signs and empty can test were X. There was X. A X was noted on X left upper shoulder, which appeared to be right where the X would attach. Range of motion was greatly diminished on the left side compared to the right. The left shoulder range of motion was flexion X degrees, extension X degrees, abduction X degrees, adduction X degrees, internal rotation X degrees and external rotation X degrees. It was opined that X had not reached maximum medical improvement but was expected to reach it on or about X. X had not yet had X. There were no records of any X on X shoulder as well. X should at least have X. It appeared that X would be a candidate for an X for the condition that was chronic or acute on the chronic condition, either way. It would appear that ODG would support X. X would be given time to have an initial course of X and then based on ODG, X may be a surgical candidate. No impairment was given due to the fact that X was not at maximum medical improvement.

An MRI of the left shoulder dated X showed a X. Tendon tearing measured X cm, allowing joint fluid to decompress into the X. There was X. There was a X. X was noted. There was X. The X was X; however, there was X. There was X. Moderate X was noted. Per an office visit dated X, an x-ray of the left shoulder showed X. There were X noted at the X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "In this case, the X claimant presents with left shoulder complaints after reporting pulling injury on X. The claimant reports left shoulder pain and weakness. Exam notes painful and limited range of motion, and X abduction and external rotation strength. The provider's reviewed MRI shows a X. The requested X is supported to address the claimant's left shoulder pain complaints and functional limitations, given the X, which is not amenable to nonoperative care. Review of the documentation supports objective findings of X impingement test. MRI reveals X. X is medically necessary in conjunction with the X to address the claimant's pain complaints due to the clinical presentation of impingement syndrome as well as prevent recurrent impingement as the claimant meets the preponderance of guideline criteria for this procedure. Documentation shows objective findings of X. Given the claimant's age, objective and imaging findings consistent X, the medical necessity for X is established to address all the pain generators in a single setting. Current evidence-based guidelines do not support the use of X due to the lack of benefit and potential harm with its use. Thus, X is not medically necessary. X would have been supported; however, as there has been no agreement to a modified treatment plan, the request in total is not considered medically necessary."

Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "In this case, the X claimant reports chronic left shoulder pain and weakness despite X with X. Exam notes painful and limited range of motion, and X abduction and external rotation strength. The provider's reviewed MRI shows a X. Give the clinical presentation of a X, the request for X is medically necessary to address the claimant's left shoulder pain complaints and functional limitations, as the condition was not amenable to nonoperative care.

Records also show objective evidence of X. Given this, the preponderance of criteria has been met to support that X is also medically necessary to prevent recurrent impingement. There are also objective findings of X. Given the claimant's age, objective and imaging findings consistent with X is a medical necessity to address all the pain generators in a single setting. The request for X is not a medical necessity, as current evidence-based guidelines do not support the use of X. X would have been supported; however, as there has been no agreement to a modified treatment plan, the request in total is not considered medically necessary."

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

Based on the submitted documentation, the requested procedure is not medically necessary. The guidelines and associated medical literature does not support the use of X. The records do reflect a X. There is also clinical examination and imaging findings to support a X. No new information has been provided which would overturn the previous denials as the use of X is not supported. X is not medically necessary and non-certified.

Non-certified.

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