

IRO Express Inc.
An Independent Review Organization
2131 N. Collins, #433409
Arlington, TX 76011
Phone: (682) 238-4976
Fax: (888) 519-5107
Email: @iroexpress.com

***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 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 at work on X. X sustained a X. The diagnoses were (X) unspecified injury of left shoulder and upper arm, sequela; (X) work related injury, (X) SLAP (superior labrum anterior and posterior) lesion, type II, nontraumatic of left shoulder, initial encounter; (X) traumatic tear of supraspinatus tendon of left arm, initial encounter; (X) bicipital tendinitis, left shoulder; and (X) impingement syndrome of left shoulder.

On X, X was seen by X, MD, for follow-up of left shoulder pain. X presented to follow-up on X MRI results. X pain was a X constantly and X was not sure if that was because of the X. X had some chronic left shoulder pain ever since a work injury. X also had some biceps and labral pathology with some labral tearing and a parallel cyst. X also had a partial articular sided supraspinatus tear. On examination, blood pressure was 142/102 mmHg, weight was 260 pounds, and body mass index (BMI) was

35.37 kg/m². Left shoulder examination revealed no tenderness. Range of motion was normal. The muscle strength was X in internal and external rotation, supraspinatus, and subscapularis. The Apprehension test, Hawkins test, and Impingement test were X. It was noted that on examination, X did have some pain but not any real weakness with muscle testing. X seemed to have a relatively normal range of motion to Dr. X actively and passively. Mr. X stated X felt like the shoulder was stiff, but Dr. X did not really appreciate any significant range of motion loss such as capsulitis or frozen shoulder. The assessment was history of motor vehicle accident, injury of left shoulder sequela, and BMI 35.0-35.9 in adult. Dr. X noted that on physical examination, Mr. X had weakness to resisted external rotation and resisted flexion, which was possibly related to the biceps and superior labrum and / or the supraspinatus tendon tear that was seen on the MRI. This had been causing X pain and disability for many years. Dr. X discussed treatment options. Surgical treatment options were discussed at length, including specifically a left arthroscopic shoulder surgery including possible labral debridement, biceps tenotomy versus tenodesis depending on the appearance of the biceps tendon, subacromial decompression, and possible rotator cuff repair. They discussed the fact that this would prolong X rehabilitation as they would have to mobilize X longer to allow the tendon to heal to bone. At the time, Mr. X was interested in X.

An MR arthrogram (MRA) on X revealed an X. There was X. There was X. No high-grade rotator cuff tear was seen.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Official Disability Guidelines (ODG) by MCG Last review/update date: Feb X, Diagnostic Arthroscopy for Shoulder Conditions Recommended (generally)R Recommended only when a definitive shoulder diagnosis cannot be made with standard imaging and examination, following X. ODG by MCG Last review/update date: X, Surgery for SLAP Lesions, Shoulder Conditions Treatment type: Surgery Conditionally Recommended--CR Recommended for persistent symptoms following X months of conservative treatment for isolated Type II or for Type IV SLAP tears involving < X of the biceps tendon anchor. In this case, the patient has left shoulder pain, decreased strength, and positive apprehension, Hawkins, and impingement tests. The patient has been treated with X. Magnetic resonance imaging (MRI) arthrogram shows X. However, there was no documentation of recent X. Therefore, the requested X is non-authorized."

Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Official Disability Guidelines by MCG (ODG) Last review/update date: X, Diagnostic Arthroscopy for Shoulder Conditions Treatment type: Diagnostic Testing, Surgery Recommended (generally)-R only when a X. ODG by MCG Last review/update date: X Surgery for X:

X. The requested X is not medically necessary. The submitted medical records do not demonstrate that the patient has attempted an appropriate course of conservative treatment including X. Note that records have not been submitted for review. Thus, the guidelines have not been met. As such, the requested X is non-authorized.”

In this case, the claimant presents with ongoing pain at the left shoulder despite use of medications. The claimant had attended X. In review of the left shoulder imaging, there was a small labral tear, moderate acromioclavicular osteoarthritis, and a low grade tear of the rotator cuff at the supraspinatus tendon. The claimant did not detail evidence of shoulder instability, significant loss of range of motion, or weakness. Given the clinical findings, failure of non-operative measures to include X. There was no indication that the claimant had X. As such, it is this reviewer’s opinion that medical necessity for the requested X has not been established and the previous denials are upheld. 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:

In this case, the claimant presents with ongoing pain at the left shoulder despite use of medications. The claimant had attended X. In review of the left shoulder imaging, there was a X. The claimant did not X. Given the clinical findings, failure of non-operative measures to include X. There was no indication that

the claimant had X. As such, it is this reviewer's opinion that medical necessity for the requested X has not been established and the previous denials are upheld. 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:

- 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