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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:

- 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 reported that a X. The diagnosis was complete rotator cuff'

tear or rupture of right shoulder, not specified as traumatic.

On X, X was seen by X, MD, for evaluation of the chief complaint of right shoulder pain. X was being re-evaluated with respect to a work-related injury on X. X had right shoulder pain ever since X injured X shoulder at work. A X of X right shoulder. Since then, X had undergone X. X continued to have right shoulder pain, especially with use. No numbness or tingling was noted. X eventually was referred after an MRI showed a cuff tear. Examination of the right shoulder revealed X pointed to the lateral aspect of X shoulder as a source of X pain. X had full range of motion at overhead, but had X abduction strength with pain on testing, X of internal and external rotation strength. X was neurovascularly intact. Review of an MRI of the right shoulder dated X showed a full-thickness anterior rotator cuff tear. X had some very X. The treatment plan was to proceed with X.

An MRI of the right shoulder dated X showed X. There was X. X 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 for denial of surgery: "The ODG supports a rotator cuff repair for documented chronic rotator cuff tears with shoulder pain and dysfunction when there is a failure of 3 months of conservative treatment. The ODG supports a distal clavicle excision for symptomatic AC joint arthritis not improved with conservative care. The ODG supports a bicep tenodesis when a history, physical exam, and imaging are indicative of biceps or SLAP pathology at the time of rotator cuff repair. The ODG supports a surgical assistant for more complex procedures. In this circumstance, the claimant reports right shoulder pain not improved with X months of X. An exam of the shoulder documented X X. An MRI of the shoulder documented a X. Given the documented shoulder pain and dysfunction, X. There is not documentation of X. There is not documentation on exam or imaging of X. A X. As such, partial certification is recommended with certification X. However, as I was unable to reach the treating physician to discuss treatment modification, the request for surgery: X, remains not certified at this time." Rationale for denial of X: "The ODG guidelines recommend X. The claimant has been authorized for a X. As such, the request X is medically necessary. However, as I was unable to reach the treating

physician to discuss treatment modification, the request remains not certified at this time.”

Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale for denial of surgery: “Per ODG by X. Surgery for X. X is recommended as an option for more X. In this case, the injured worker had right shoulder pain. X had undergone X. On right shoulder examination, X pointed to the lateral aspect of X shoulder as a source of X pain. X had full range of motion overhead but had X abduction strength with pain on testing. Reviewed MRI of right shoulder showed a full-thickness anterior rotator cuff tear. X had some very mild X. There was X. In this case, there was lack of significant findings on physical examination. There was no documentation of X months of X. There was no documentation on exam or imaging of X. Thus, the request for X is not medically necessary.” Rationale for denial of X: “Per ODG by MCG, X. The associated surgery is not medically necessary. Thus, the request for X is not medically necessary.”

Based on the submitted documentation, the requested X is not medically necessary. The submitted imaging reports do not support a X. The imaging report only demonstrates X. The MRI scan does not support X. No additional information has been provided which would overturn the previous denials. 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:

Based on the submitted documentation, the requested X is not medically necessary. The submitted imaging reports do not support a X. The imaging report only demonstrates X. The MRI scan does X. No additional information has been provided which would overturn the previous denials. 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