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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

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Case Number: X Date of Notice: X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X sustained a work-related right shoulder injury X. The diagnosis was traumatic complete tear of right rotator cuff.

On X, X was seen by X, MD for continued severe difficulty with the right arm. The X was denied. Examination of the shoulder revealed forward elevation to X degrees, and with assistance X degrees; external rotation to X degrees; and internal rotation to the X level with discomfort. The motion was improved passively without evidence of adhesive capsulitis. There were significantly X. Tenderness was noted over the X. Internal and external rotation of the arm at the side revealed X. There was significant X. Given the full thickness tear with significant functional loss, X was again recommended. On X, X visited Dr. x to recheck right shoulder follow-up. X continued to have significant difficulty with X arm. Examination of the shoulder revealed forward elevation to X degrees, and with assistance X degrees; external rotation to X degrees; and internal rotation to the X. Pain was again noted with range of motion especially forward elevation. There were X. Hawkins test was X. A significantly X. Tenderness was noted over the X. Internal and external rotation of the arm at the side revealed X. Rotator cuff strength testing in both forward elevation, abduction and external rotation showed strength deficits. Significant X was noted with abduction strength testing and also external rotation strength testing. Discomfort was also noted with strength testing. A X drop arm test X. This was consistent with a X. A palpable click was also noted with testing. There was significant weakness. No muscular X to suggest chronicity was noted.

An MRI of right shoulder dated X reported that there was a X. Acromioclavicular joint was X. The long head of the biceps was X. There was X.

Treatment to date included is not included in the records.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "In this case, the patient sustained a work-related right shoulder injury while X. A magnetic resonance imaging (MRI) revealed a X. The rotator cuff muscles were noted to be X. A physician recommended X. The proposed treatment plan includes X. Additionally, X was deemed medically necessary for the right shoulder following the procedure. Regarding the current request, the patient has shoulder pain secondary to a X. The patient sustained an X. Magnetic resonance imaging (MRI) confirms the presence of X. The recommendation is for a X. However, the imaging does not reveal evidence of X. A modification of the requested service for the shoulder X does meet guideline criteria. However, modification of the requested service is not allowed in the state of Texas without approval from the treating provider. Therefore, the request for X is not medically necessary." X was denied. Rationale: "Regarding the current request, the guidelines do not pertain, as the X is not supported. As the X is not medically necessary, the X are not indicated. Therefore, the request for X is not medically necessary."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was upheld by X, MD. Rationale: "Based on the review of the provided documentation, the claimant is a X who was injured on X. The claimant was X. A X physical examination notes forward elevation to X degrees with external rotation to X degrees. The motion is improved passively without evidence of X. There are X. There X. A X right shoulder MRI report states that there is a X. The long head of the biceps is X. The request was previously denied on X peer review. The ODG recommends X. The ODG recommends X. The ODG recommends X. The ODG recommends X. In this case, there is a X. There is no evidence of X. There is x. Given the X, X is supported to confirm the X. Although

there are amendments signs in a X on examination, there is no evidence of X. As such, modified certification is recommended with certification of APPEAL: X. However, there was no successful peer discussion to discuss the treatment modification, the request cannot be modified as this is required in Texas cases. Therefore, the request for X is recommended upheld X was upheld. Rationale: "Based on the review of the provided documentation, the claimant is a X. The claimant was X. A X physical examination notes forward elevation to X degrees with external rotation to X degrees. The motion is improved passively without evidence of X. There are significantly X. There is X. A X right shoulder MRI report states that there is a X. The long head of the biceps is X. The request was previously denied on X peer review. The ODG X. The ODG recommends X. The ODG recommends X. The ODG recommends X. In this case, there is X. There is no evidence of X. There is significant X. Given the X. Although there are X. As such, modified certification is recommended with certification of APPEAL: X. However, there was no successful peer discussion to discuss the treatment modification, the request cannot be modified as this is required in X cases. Therefore, the request for APPEAL: X is recommended upheld."

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

Given the X. Although there are X. As such, modified certification would be recommended with certification of X. However, there was no successful peer discussion to discuss the treatment modification, the request cannot be modified as this is required in X cases. The X would not be indicated when the surgery is not recommended. Therefore, the request for X is not medically necessary and the determination is upheld.

Upheld

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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