Applied Assessments LLC

Notice of Independent Review Decision

Case Number: XX Date of Notice: 1/9/2019 1:13:35 PM CST

Applied Assessments LLC

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IRO REVIEWER REPORT

Date: 1/9/2019 1:13:35 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX XX x 30 day XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Orthopaedic Surgery

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

PATIENT CLINICAL HISTORY [SUMMARY]: XX. XX XX is a XX XX who sustained a XX injury on XX to XX XX XX when XX XX and XX fell on XX XX side. On XX, XX performed XX shoulder XX rotator cuff repair, single XX, XX, biceps tendon XX XX-assisted / open, and XX XX, extensive. The postoperative diagnoses were XX shoulder XX XX tear, impingement, XX, and mild XX. XX evaluated XX. XX on XX for a follow-up. XX. XX complained of XX / XX pain. The XX pain had been present since XX after the XX. XX had not yet returned to work and stated they did not have any light duty for XX. On examination, XX had tenderness in the XX XX, XX, and XX muscle with a taut XX. There was XX tenderness. Range of motion of the XX XX was decreased by XX%. XX shoulder was in a XX. XX had pain in the XX shoulder. XX shoulder XX and XX were positive. XX had a XX Tinel's and Phalen's on the XX wrist. The assessment was XX strain, XX strain, XX, and XX; XX and XX XX; XX pain; impingement; XX XX tear; XX pain, and XX XX surgery. The plan was to continue the home exercise program (HEP) for XX shoulder, XX stabilization exercise and stretch, and therapeutic exercise. A prescription for XX gel was given. XX was continued. On XX, XX provided a prescription for XX shoulder XX for the diagnoses of pain in the XX XX, adhesive XX of the XX XX, and XX XX of the

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XX XX. On XX, XX evaluated XX. XX for physical therapy re-examination. The treatment diagnosis was XX shoulder pain. XX. XX was progressing at a slow rate. XX remained limited in active range of motion (AROM), pain limiting XX from going beyond a certain range. XX had progressed well with strength gains. XX remained limited in functional activities including reaching for XX XX, XX XX, donning / doffing inner wear, pulling and pushing. XX primary concern was about increased pain, overhead motions, and reaching for the XX. XX XX flexion was XX degrees, XX was XX degrees, abduction was XX degrees, extension was XX degrees, functional external rotation reach was to XX, functional internal rotation reach was to XX, external rotation in neutral position was XX degrees, internal rotation in neutral position and horizontal abduction was XX degrees, and horizontal adduction was XX degrees. XX passive range of motion included flexion of XX degrees, scaption of XX degrees, abduction of XX degrees, extension of XX degrees, external and internal rotation in neutral position was XX degrees. XX had muscle guarding during all these motions. XX had difficulty manipulating objects, holding objects, opening / closing lids; difficulty with heavy duty tasks at home; difficulty with pulling, pushing, lifting objects from the floor; increased muscular tightness and soft tissue restrictions; pain with forward reaching, sudden cramping in the XX XX, difficulty XX, manipulating objects with XX hand; limitation with carrying, moving, and handling objects. The plan was to proceed with physical therapy XX to XX times a week for XX weeks. The treatment interventions included therapeutic exercises, therapeutic activity, neuromuscular rehabilitation, manual therapy, massage, XX / taping, and self-care. XX provided a prescription for XX on XX. An XX study (XX) of the XX extremities done on XX revealed mild XX. An MRI of the XX XX done on XX revealed XX and mild XX. An MRI of the XX XX obtained on XX revealed XX insertion with a small full-thickness component measuring approximately XX; XX; moderate XX, likely secondary to the XX XX tear (XX); mild XX, and XX. The treatment to date consisted of medications (XX gel and XX), XX XX XX XX XX repair, and physical therapy. Per a utilization review determination letter dated XX, XX documented that the requested service of XX XX XX XX x 30 days XX (XX) was not certified. Rationale: “Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, XX (XX) are alternative options in conjunction with continued physical therapy if XX weeks of PT alone has been clearly unsuccessful in adequately correcting range of motion limitations secondary to refractory adhesive XX, otherwise needing manipulation and / or XX. In this case, the patient underwent XX XX XX repair, XX, XX, and extensive XX on XX. The most recent PT report on XX showed the patient had increased soreness and stiffness. However, there were limited PT reports submitted for comparison to fully establish that PT had clearly failed. Based on the information provided, guidelines reviewed and lack of successful peer discussion, the request is not medically supported at this time and thus, non-certified.” Per a utilization review determination letter dated XX, XX documented that the appeal request of XX XX shoulder XX x 30 days, rental (XX) was not medically necessary. Rationale: “Based on the clinical information submitted for this review and using the evidence-based peer-reviewed guidelines referenced above, this request is non-certified. There were still limited PT reports submitted for comparison to fully establish that PT had clearly failed. Clarification is needed regarding the request and how it might affect the patient's clinical outcomes. Exceptional factors could not be clearly identified.”

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

The ODG states that the use of a XX is under study for XX XX but notes that while this device cannot yet be broadly recommended, it is an alternative option in conjunction with continued physical therapy of XX weeks of physical therapy alone has been clearly unsuccessful in adequate correcting range of motion limitations secondary to refractory XX XX otherwise needing manipulation and/or XX. The ODG states that in this situation, it could be considered on a case-by-case basis for an initial four-week XX XX in conjunction with physical therapy as an alternative to more invasive (and costly) surgical procedures. The provided documentation reveals evidence of persistent XX XX stiffness approximately XX and half months out from an XX XX XX repair, XX, XX and XX. The physical therapy report from XX reveals flexion of XX°, abduction of XX°, external rotation of XX°, and internal rotation of XX°. The therapist indicates that the injured worker continues to make progress with therapy but at a slow rate. Given that there has not been a treatment failure with physical therapy,

and there is no evidence that the XX is being requested as an alternative to surgical intervention, the requested XX XX XX XX x 30-day rental is not medically necessary. Recommendation is to uphold the two previous denials.

Given the documentation available, the requested service(s) is considered not medically necessary and the decision is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG, 2018: XX