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Notice of Independent Review Decision
Amendment X

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 Overtuned 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. The biomechanics of the injury was not available in the provided records. The

diagnosis included right shoulder rotator cuff tear, right shoulder subacromial impingement and right shoulder full thickness supraspinatus tendon tear without retraction. On X, X presented to X, MD for follow up visit regarding X right shoulder. X rated X pain X at the time and X at worst. X stated X had completed X sessions of X. X stated X continued with range of motion and noted X had difficulty with lifting any heavy objects. X stated X noted some improvement with X. X reported the use of over the counter (OTC) X as needed for pain. On physical examination of the right shoulder, there was pain on palpation at X. Active range of motion showed flexion to X degrees, abduction to X degrees, external rotation to X degrees, internal rotation to X degrees, extension to X degrees, and adduction to X degrees. X was noted. A X was recommended. If X did not meet the required physical demand level, an X hour return to work program was recommended. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the prospective request for X is non certified. Rationale: “According to evidence-based guidelines, X is conditionally recommended. Not recommended for screening or routine monitoring of rehabilitation programs Including physical therapy or work conditioning, for prediction of future reinjury, for establishing maximum medical improvement (MMI) or permanent work restrictions, or for rating permanent impairment. FCE may be indicated when all of the following are met: Worker actively participates in decision to return to specific job. Job demand analysis or Job description is available to examiner. Worker has new injury with confirmed objective deficit on physical examination and unknown work capacity. Worker is not currently enrolled in X. X is tailored to worker's specific job task or essential job duty and is specific to region of injury. In this case, the claimant sustained a work-related Injury on X. X is status post right shoulder diagnostic arthroscopy with revision of rotator cuff tear, limited debridement of the labrum, revision of the subacromial decompression, injection of platelet-rich plasma on X. X has completed X out of X sessions of X. On physical examination of the right shoulder, there was pain on palpation at X. Active range of motion showed flexion X degrees, abduction X degrees, external rotation X degrees, internal rotation X degrees, extension X degrees, and adduction X degrees. X test noted. However, there is no documentation of any job description, job demand analysis or claimant's decision towards returning to the job. Pending this information, the request for X is noncertified. “Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X is non certified. Rationale: “Per the Utilization

Review dated X, the request for X is noncertified due to no documentation of any job description, job demand analysis or claimant's decision towards returning to the job. Since the requesting provider did not answer the prior utilization review non-certification, hence the current appeal request is for X is noncertified. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request is non-certified. “The ODG supports a X when case management is hampered by complex issues, timing is appropriate, there are objective deficits, and there is an unknown work capacity. Additionally, the worker should not currently be enrolled in a rehabilitation program and they should be actively participating in a decision to return to specific job. The documentation provided indicates that the injured worker reports right shoulder pain. They have undergone surgical intervention and X visits. On exam they X of flexion, X abduction, X° external rotation, and positive impingement. The provider recommended an X following the completion of X and noted if a required X was not met, a return to work program would be recommended. When noting that the injured worker has not yet completed X, there is not documentation they are at maximum medical improvement, and there is no documentation that case management has been hampered by complex issues, a X is not supported. As such, X is not medically necessary and noncertified.

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

The ODG supports a X when case management is hampered by complex issues, timing is appropriate, there are objective deficits, and there is an unknown work capacity. Additionally, the worker should not currently be enrolled in a rehabilitation program and they should be actively participating in a decision to return to a specific job. The documentation provided indicates that the injured worker reports right shoulder pain. They have undergone surgical intervention and X visits. On exam they X of flexion, X abduction, X external rotation, and positive impingement. The provider recommended an X following the completion of X and noted if a required X was not met, a return to work program would be recommended. When noting that the injured worker has not yet completed X, there is not documentation they are at maximum medical improvement, and

there is no documentation that case management has been hampered by complex issues, a X is not supported. As such, X is not medically necessary and noncertified.
Upheld

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

☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

☐ **INTERQUAL CRITERIA**

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

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**