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Notice of Independent Review Decision

Amendment X

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IRO REVIEWER REPORT

Date:X: AmendmentX;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]:

No new office visit is provided X who sustained an injury on X. The biomechanics of the injury is not available in the provided records. The diagnoses included incomplete rotator-cuff tear / rupture of left shoulder, not trauma. Per the prior review, on X, X presented to X, MD with complaints of left shoulder pain. The examination revealed a range of motion active forward extension of X degrees, a passive forward extension of X degrees, passive external rotation at the side to X degrees, and active internal rotation to the lumbar spine. Strength in supraspinatus and subscapularis was X, infraspinatus X. X test, positive X. X-Rays of the left shoulder dated X revealed X. Per the prior review, an X dated X revealed a X. Treatment to date included X. Per the Physician Advisor Determination by X, MD on X, the request for X was non-certified. Rationale: “Per ODG, Continuous-X is "not recommended since continuous- X ". There is no evidence that the patient is unable to X. This request is secondary to the indicated surgery. Thus, medical necessity has not been established. Therefore, the request for X is non-certified.” The request for X was non-certified. Rationale “This request is secondary to the indicated surgery. Thus, medical necessity has not been established. Therefore, the request for X is non-certified.” The request for X, was noncertified. “Based on the provided documentation, the patient presented to Dr. X with complaints of left shoulder pain. The examination revealed a range of motion (ROM) active forward extension of X degrees, a passive forward extension of X degrees, passive external rotation at the side to X degrees, and active internal rotation to the lumbar spine. Strength supraspinatus and subscapularis X out of X, infraspinatus X out of X. Positive Whipple test, positive painful arc, positive Belly press, positive lift off, positive impingement Neers and Hawkins sign, and positive Speed's test. X-Rays of the left shoulder dated X revealed X. space narrowing. X space narrowing. No significant X. Magnetic resonance imaging (MRI) of the left shoulder dated X revealed a X. The patient has been treated with X. The patient has X. However, a component within this review was denied. TX jurisdiction does

not allow for modification without AP agreement. Therefore, the request for X is not medically necessary. Therefore, the request for X is non-certified. “Per Physician Advisor Determination by X, MD on X, the request for X was non-certified. Rationale: The claimant has a X is not supported by ODG. Therefore, X was non-certified.” The request for a X is not medically necessary. Rationale: ”The claimant will require surgery for treatment of this X. Postoperative use of a X is supported. However, the provider could not be reached for modification. Therefore, X is not medically necessary” X was not medically necessary. Rationale:” The claimant has a X. ODG supports surgical treatment. However, the provider could not be reached for modification. Therefore, X is not medically necessary. “The claimant has an X. Based on the exam findings and guidelines the requested X is supported. However, X are not supported Official Disability Guidelines. Based on review of the provided records, the request for X is medically necessary and certified. The requested X is not indicated because peer-reviewed literature does not X. Based on review of the provided records, the request for 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:

The claimant has an X. Based on the exam findings and guidelines the requested X is supported. However, X are not supported Official Disability Guidelines. Based on review of the provided records, the request for X is medically necessary and certified. The requested X is not indicated because peer-reviewed literature does not X. Based on review of the provided records, the request X is not medically necessary and non certified

Partially Overturned

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

☐ 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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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

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

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL