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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 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:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a X. A review of the medical records indicates that the injured worker is undergoing treatment for X.

Prior diagnostic testing included an MRI of the left shoulder dated X has X. Previous treatment has included medications- X. Previous surgeries included X on X.

Progress report dated X has the injured worker with pain level rated at X at rest and increases to X with movement. X notes the overall left shoulder symptoms have decreased. The X has increased. The X has X. X does note pain with X. The left shoulder exam reveals X. The X is abduction X, flexion X, internal rotation X, and external rotation X which are increased. There is X. The left shoulder X-rays were noted to show X. The treatment plan included medications and X. Consultation dated X has the injured worker with X. The exam reveals left shoulder forward flexion X, external rotation X, and abduction X. There is a X. The treatment plan included X. Progress report dated X has the injured worker with left shoulder pain rated at X. The exam reveals the wound is clean. The treatment plan included X. Progress report dated X has the injured worker with X

rated X. The treatment plan included medications and follow-up. Progress report dated X has the injured worker with X rated at X. The exam reveals forward flexion X, external rotation -X, and abduction X. Strength is X in supraspinatus. The treatment plan included X. Progress report dated X has the injured worker with left shoulder pain that is rated at X. The left shoulder exam reveals forward flexion X, external rotation X, and abduction X. The treatment plan included X. Progress report dated X has the injured worker with left shoulder pain that radiates to the hand with pain. X has finished therapy. The exam reveals no change in X. The treatment plan included an MRI and follow-up.

Follow-up evaluation dated X has the injured worker with right upper pain and left upper arm pain. The pain is rated at X and increases to X when X lifts X arms. X notes the left shoulder symptoms have overall increased. X has pain rated at 9. There is weakness that has remained the same. X continues with stiffness to the arm and mass to the proximal shoulder. The exam of the left shoulder reveals X. The range of motion remained the same with abduction X, forward flexion X, internal rotation X, and external rotation X. X is decreased. The treatment plan included medications, therapy, and follow-up. Progress report dated X has the injured worker with left shoulder pain rated at X. The exam reveals a left forward flexion X, external rotation X, and abduction X. Strength is X in X. The treatment plan included a X.

Utilization Review dated X non-certified the requested X. The rationale stated there is no indication that the patient has X. The request is not medically necessary. Utilization review dated X non-certified the requested X. The principal reason for the determination states a more recent medical note is required to demonstrate the X and the rationale for the requested procedure. There is no documentation that the patient has X.

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

As per ODG, “X
X.”

This X sustained an industrial injury on X, is seeking authorization for X. X presented on X with left shoulder pain rated at X. The exam reveals a left forward flexion X, external rotation X, and abduction X. Strength is X in X. However, detailed documentation regarding a trial and failure of recent, reasonable, comprehensive, less invasive conservative care measures is not evident. There is X. The ODG (Official Disability Guideline) criteria have not been met. No compelling rationale is presented or extenuating circumstances noted to support the medical necessity of this request as an exception. Therefore, the requested X is not medically necessary.

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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

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

☐ **PRESSLEY 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)**