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Notice of Independent Review Decision
Amendment X
Amendment X

IRO REVIEWER REPORT
Date: X; Amendment X; 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 Overtuned (Agree in part/Disagree in part)

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who sustained an injury on X. X claimed that a X. X had to X. Afterwards X started with pain on X left shoulder. The diagnoses included left shoulder-strain / sprain and left shoulder anterior labral tear.

X was seen by X, MD on X for left shoulder pain. X noted minimal pain to X left shoulder at rest. X stated X pain levels at times could increase to an X with certain movements, especially at nighttime. X claimed lo having popping of the shoulder while doing daily activities. X had limited any heavy lifting activities as that caused increased pain. Left shoulder examination revealed X. There was tenderness over X. Range of motion revealed flexion X degrees, abduction X degrees with pain, external rotation X degrees, internal rotation X degrees, extension X degrees, adduction X degrees. Speed's test, Neer's test, Hawkin's test, and apprehension tests were X. Resisted flexion of the left arm caused increased left shoulder pain. It was noted that X continued with signs of impingement and much pain. On X, X presented for left shoulder pain. X rated X pain X. X claimed that pain could aggravate with reaching overhead and lifting items. X received a denial on the recommended surgery. X continued with X. Left shoulder examination revealed X. There was tenderness over X. Range of motion revealed flexion X degrees, abduction X degrees with pain, external rotation X degrees, internal rotation X degrees, extension X degrees, adduction X degrees. Speed's test, Neer's test, Hawkin's test, and apprehension tests were X. Resisted flexion of the left arm caused increased left shoulder pain. It was noted that X continued with signs of impingement and much pain.

An MRI of the left shoulder on X showed X.

Treatment to date included X.

Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “Per ODG X. Evidence Summary: Orthopedic surgeons can usually determine correct diagnoses through physical examination and imaging studies alone. X." In this case, the patient has been followed for ongoing complaints of left

shoulder pain, which was severe at X. No prior treatment records were included for review that detail the failure of non-operative measures. A successful peer-to-peer call with X, specified designee for X, MD occurred. Per the peer conversation, the details of the request were discussed. The designee noted that additional records would be faxed for review. Additional records were received for review tl1.at included the previously reviewed clinical report dated X and the left shoulder MRI report dated X which noted X. There was a labral tear present anteriorly. No significant X was detailed in the report. The X left shoulder radiograph report was X. No other treatment records were received for review. As such, the request is not shown to be medically necessary and is non-certified." The request for X was noncertified. Rationale: "Per ODG Surgery for X, "Recommended as a treatment option; may be a first-line or second-line treatment option. ODG Criteria: Surgery for X may be indicated when all of the following are met: Planned procedure is X. Planned procedure is performed X. X documented on imaging studies (eg, magnetic resonance imaging). Lack of improvement with conservative therapy for al least X months X). Significant pain or functional impairment of the shoulder. In this case, the patient has been followed for ongoing complaints of left shoulder pain, which was severe at X. No prior treatment records were included for review that detail the failure of non-operative measures. A successful peer-to-peer call with X, specified designee for X, MD occurred. Per the peer conversation, the details of the request were discussed.

The designee noted that additional records would be faxed for review. Additional records were received for review that included the previously reviewed clinical report dated X and the left shoulder MRI report dated X which noted X. There was X. No significant X was detailed in the report. The X left shoulder radiograph report was X. No other treatment records were received for review. As such, the request is not shown to be medically necessary and is non-certified." X was non-certified. Rationale "In this case, the overall X are not medically necessary. As such, this request is also not medically necessary and is non-certified."

Per the peer review by X, MD on X, the request for X was non-certified: "Per ODG guidelines, X is recommended only when a X. Per ODG guidelines, Surgery for X may be indicated when all of the following are met: Planned procedure is X.

Planned procedure is performed X. Impingement documented on imaging studies (eg, magnetic resonance imaging) Lack of improvement with X. A prior denial by Dr. X dated X, was denied on the basis there were no treatment records provided for review. It is noted the patient has tried X. However, there is no evidence the patient has tried a X, X to support the request. Therefore X is non-certified." The request for X was certified. Rationale: "Based on the provided documentation, the patient presented pain in the left shoulder at rest, the pain levels can increase to X with certain movements, especially at night. There was also reported popping in the shoulder while doing daily activities and lin1iting heavy lifting activities as this causes increased pain. The examination revealed X. It is noted the patient has tried X. Per ODG guidelines, X for shoulders is recommended only when a definitive shoulder diagnosis cannot be made with standard imaging and examination, following failure of conservative treatment including physical therapy. ODG does not specifically address the request for X. Therefore, medical literature was consulted. Per medical literature, Consecutive patients diagnosed with X. A prior denial by Dr. X dated X, was denied on the basis there were no treatment records received for review. A magnetic resonance imaging (MRI) of the left shoulder without contrast dated X, revealed X. Given the ongoing pain, mechanical symptoms, objective findings, and failure of physical therapy, the requested surgery is warranted. Therefore, X is certified."

Thoroughly reviewed provided records including clinical notes, imaging results, and peer reviews. Based on the ODG criteria, the request for diagnostic X. The MRI findings and exam are consistent with an X. The claimant continues to have pain, and has completed X months of conservative treatment. However, the records indicate X. The medical records that clearly demonstrate X. No new information has been provided which would overturn the previous denials : 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:

Thoroughly reviewed provided records including clinical notes, imaging results, and peer reviews. Based on the ODG criteria, the request for X. The MRI findings and exam are consistent with a X. The claimant continues to have pain, and has completed X months of conservative treatment. However, the records indicate X.

The medical records that clearly demonstrate X. No new information has been provided which would overturn the previous denials. : X is not medically necessary and non certified.

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)**