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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 who sustained an industrial injury on X and is seeking authorization for a X. A review of the medical records indicates that the injured worker is undergoing treatment for X.

The X magnetic resonance imaging of the left shoulder has X. Findings include X.

The X x-rays of the left shoulder have impressions of since the previous study, X. Previous treatment has included a sling and medications. Previous surgeries included X on X.

The X Orthopedic Surgery report cites X was doing well up until X weeks ago when on X X was at work and had to X. X had a magnetic resonance imaging of the left shoulder. X has pain rated at X that is stabbing, dull, and aching. The exam reveals well-X. X has tenderness to palpation. There is X. X has pain with palpation of the X. Active range of motion is X in forward elevation, X in external rotation, and left hip internal rotation. There is X. The treatment plan included X.

The X Orthopedic Surgery report cites X has complaints of numbness in the small, ring, and long

fingers. X has been placed into a X. X is having flushing and twitching in bed from administration of this as well as nausea. X is an everyday smoker of 0.5 packs per day of cigarettes. The left shoulder exam reveals X. There is tenderness to palpation. There is a X noted. There is X. Active range of motion is X in forward elevation, X in external rotation, and internal rotation to the left hip. There is X. The treatment plan included a X.

The utilization review dated X non-certified the requested X. The rationale stated no recent non-operative measures were detailed. The current physical exam did note X. No provocative findings were detailed in the current physical exam. Given the limited exam findings and the lack of documentation regarding the failure of recent non-operative measures, certification for the surgical request is not recommended and is non-certified.

The utilization review dated X non-certified the requested X. The rationale stated the guideline criteria cannot support surgical intervention since the injured worker was not documented to have X. Additionally, the injured worker was noted as doing well and the X. Therefore, medical necessity has not been established.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION.

As per ODG, “Surgery for X may be indicated when all of the following are met: Planned procedure is X. Planned procedure is performed coincident with surgery for X. X documented on imaging studies (e.g., magnetic resonance imaging). X. Significant pain or functional impairment of the shoulder”
As per X, “Currently, there are multiple described surgical techniques for X. Historically, first-generation X. However, complications including X. The X, was previously the most frequently used method to X.

Recently, newer techniques for X. These techniques most commonly include the use of a X. Biomechanically, this construct has been shown to be equivalent to X. X has decreased the risk of X. However, there is still concern of X.”

This X sustained an industrial injury on X, is seeking authorization for a X. X is status X on X. X presented on X with complaints of numbness in the small, ring, and long fingers. X has been placed into a sling and X is not tolerating the X. X is having flushing and twitching in bed from administration of this as well as nausea. X is an everyday smoker of 0.5 packs per day of cigarettes. The left shoulder exam reveals well-X. There is tenderness to palpation. There is a X noted. There is pain with palpation of the X. Active range of motion is X in forward elevation, X in external

rotation, and internal rotation to the left hip. There is X.

However, detailed documentation regarding a trial and failure of recent, reasonable, comprehensive, less invasive conservative care measures is not evident. Additionally, the provided magnetic resonance imaging of the left shoulder dated X did not X. The Official Disability Guidelines have not been met for the requested X. Moreover, the requested X. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception. Therefore, the request for 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 X

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