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Notice of Independent

Review Decision **IRO REVIEWER REPORT**

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:

X 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]:
The patient is a X whose date of injury is X. The patient underwent right shoulder X on X and has completed X visits to date. Per Dr. X on X, it is noted that the patient is making progress, and X would like to try X. The physical examination reveals X of the right shoulder. X has pain with X. The assessment is right shoulder X. The treatment plan is to X. Per the X report by X, PT, DPT, the patient is being seen for visit
Number X. The patient presents to X to right biceps X is and shoulder X performed on X. The patient states X has been using the shoulder X as instructed by X physician, as well as an X. The patient reports X is still having difficulty with X. On the physical examination, X is X degrees and X is X degrees. X has improved since X , from X. The patient has X in the shoulder especially when X is over X. It is noted that the patient should continue with X. Office visit note dated X indicates that overall X has basically X. It has been X since X last had therapy. X works as a X. X has been trying to exercise at X but X has not really been able to progress to increase X. On exam X has X. X is X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. The initial request was non-certified noting that the Official Disability Guidelines recommend X. Within the documentation provided for review, the patient underwent a X. Per the X physical therapy record, the patient has had at least X. The patient has made improvements in X. The patient still has limitations affecting X activities of X. However, the requested session exceed the guideline recommended duration. There is no documentation contraindicating a X. The denial was upheld on appeal noting that the prior treatment has included X. The provider notes there has been a X since initiation of the X. There were no exceptional factors that would support authorization of X. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient

underwent right shoulder X. Current evidence based guidelines support up to X. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The patient has completed X. Therefore, based on the clinical information provided, the request for X is not recommended as medically necessary.

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

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES