Independent Medical Reviews LLC
17304 Preston Road, Suite 800 | Dallas, Texas 75252
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

DATE OF REVIEW: 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]:

The patient's diagnoses include a right rotator cuff tear, subacromial impingement, and biceps tenotomy. On X, a physician review considered a request for X. The reviewer noted that screening should include assessment of the claimant's attitude/behavioral and testing to make sure there were not psychosocial or significant pain barriers in such a program. The reviewer noted that this claimant's job places X in a medium physical demand level

and that a functional capacity evaluation revealed X functioning at a light/medium level. The reviewer concluded that X was not medically necessary. On X, a physician review again considered a request for X. The reviewer noted that a physical therapy notes of X indicated that the claimant underwent a functional capacity evaluation which revealed several deficits preventing return to X job which required prolong standing, walking, bending, squatting, overhead reaching, gripping, and lifting/carrying up to 50 pounds. The reviewer noted that the current request could be considered but the guidelines would only support X. For that reason, the request was considered to be not medically necessary. An appeal note at this time from X reveals that X was requested. The appeal notes that the request is indeed for X. A functional capacity evaluation of X notes the claimant reports that Xjob as a X places X in the medium physical demand level, the claimant is lifting 50 pounds infrequently or 25 pounds frequently.

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

Per ODG references, the requested X is not medically necessary for the patient. The Official Disability Guidelines discusses the principles of a X. X may be indicated in situations where a patient plateaus in traditional physical therapy and has remaining functional restrictions precluding return to work based upon an employer verified job description.

The functional capacity evaluation in this case appears to be based upon a verbal description of the job by the claimant and not based upon a specific employment verified job description. Without such additional details, it is not possible to support the request as medically necessary.

The request should be noncertified.

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 KNOWLEDGE BASE
- ☐ AHCPR- 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