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Notice of Independent Review Decision

Amendment X

IRO REVIEWER REPORT

Date: 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 Overturned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X was involved in a X. X was driving near "X" in X , and there was X. X and X. X had immediate left-sided shoulder pain. The diagnosis was other instability, left shoulder and anterior subluxation of left humerus. On X, X was seen by X, MD for a follow-up visit. X presented for evaluation of left shoulder pain. X rated the pain a X. Since the accident, X was seen in the emergency department and had since been seen by X. At the time, X returned for repeat evaluation. X had received an X. X was still having difficulty with shoulder pain. The left shoulder examination revealed that X had X. X did have some X. X also had a X. X had a X. Dr. X pulled up images of the X and found X to have some X. The assessment was other instability, left shoulder and anterior subluxation of left humerus. The findings were discussed with X. This was really something greater than a X. At that point, Dr. X thought X. X wished to proceed with X and clearance for this would be obtained. An MRI of the left shoulder post arthrogram dated X revealed X. There was X seen. There X. There was X. X was X. There was X. There was X. There was X. There was X. There was X. X was seen. X was X. X or significant was noted and X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The records submitted for review would not support the requested X as reasonable or necessary. The claimant had reported ongoing left shoulder pain with the current physical exam noting X. There were X noted on the current MRI report. However, the records did not detail failure of X. Given these issues which do not meet guideline recommendations, I cannot recommend certification for the request. "Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "ODG provides criteria for X. There should be a history, X. Regarding direct repair, this is recommended for X. In this case, the claimant is a X who complains of chronic left shoulder pain. There is no documentation of X. X is not warranted for claimants over the age of X. Given these noted factors, the medical necessity of this request is not established. Recommendation is to deny X." Based on the submitted

medical records, the patient has not attempted a minimum of X. The records do not reflect functional limitations. The records indicate that the patient is X years of age. No new information has been provided which would overturn the previous denials. The requested service is not consistent with the guidelines or the standard of care. 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:

Based on the submitted medical records, the patient has not attempted a minimum of X. The records do not reflect functional limitations. The records indicate that the patient is X years of age. No new information has been provided which would overturn the previous denials. The requested service is not consistent with the guidelines or the standard of care. X is not medically necessary and non certified

Upheld

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

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL