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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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 at work X. X was X. The diagnosis was sprain of unspecified parts of right shoulder girdle and strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder. On X, X was evaluated by X, PT for physical therapy evaluation for pain in the right shoulder. At that time, X reported increased pain and decreased mobility of X right shoulder. X rated the pain was constant at X at rest and X during shoulder elevation. On examination, X had X. X had a forward X. The X of the right shoulder revealed X. On assessment, X presented with constant pain and X. X also presented with X. X interventions were recommended to address X. On X, X was seen by X, MD /X, MD for follow-up evaluation. X presented to the clinic for a right shoulder complaint. X reported a pain level if X. X stated that overall, the symptoms had remained the same. X rated the pain at that time a X. X remained the same. X remained the same. X saw Dr. X in X, and had been recommended X. X was denied twice and now was under third appeal. On examination, blood pressure was 130/90 mmHg, weight 198 pounds and BMI 28.4 kg/m2. The right shoulder examination revealed X. X remained the same. X showed X remained the same. X remained the same. X remained the same. X was suggestive of rotator cuff tear. X-rays of the right shoulder dated X were negative for X. The diagnosis was sprain of unspecified parts of right shoulder girdle, subsequent encounter; and strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder, subsequent encounter. X was advised to take over-the-counter medication as needed. X had plateaued with X, and surgical

intervention was indicated. X would be encouraged to engage with adjuster regarding appeal. Dr. X would consider a X was denied a third time. MRI revealed X. Referral to the orthopedic specialist for the right shoulder, would be ordered on X. X was recommended restricted duty work status. An MRI of the right shoulder dated X revealed there was a X. There was a small associated X. There was a X. This could represent a X. There was 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: “Regarding X, ODG states that X is recommended as an option, maybe a first-line or second-line option. X may be indicated for X. X note that X. Good results with low complication rates have been reported. Indications include X. In this case, the claimant is X years of age. Review of clinical documentation does not document evidence of inability to elevate the arm or externally rotate the arm against resistance. There are no provocative tests on physical exam. There is no orthopedic report outlining a specific surgical plan and no rationale for X. The records do not support that the claimant meets indications for X. As the entirety of the X is not supported as medically necessary and there was no opportunity to discuss treatment modification, the request for X is not medically necessary. Recommendation is to deny. “Per a reconsideration review adverse determination letter dated X by X, MD, the appeal 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 pain at the right shoulder despite prior use of X. However, the records did not include any formal imaging reports for the right shoulder detailing the extent of X. Further, the current physical exam was non-specific regarding the right shoulder. Given these issues which do not meet guideline recommendations, I cannot recommend certification for this request. “The requested X is not medically necessary. Based on the submitted medical records, the entire X is not supported as no rationale is given for the X. The medical records do not demonstrate X. No recent examination has been provided. No

new information has been provided which would overturn the previous denial. 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:

The requested X is not medically necessary. Based on the submitted medical records, the entire X. The medical records do not demonstrate X. No recent examination has been provided. No new information has been provided which would overturn the previous denial. 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