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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 Overtuned 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 worked as a X. A X was trying to X. X restrained the X. The X was X. X was holding the X. The diagnosis was pain in the right shoulder. X was seen by X, MD on X for evaluation. X reported X had been feeling a lot better with the arm and shoulder. X reported X continued X. X had an X and was awaiting approval for more. X had a re-evaluation. X continued to have painful twinges in muscles at times but less. X had X at the time and showed the same in X . X was sorer after therapy. There were no interval injuries. On examination, extremities demonstrated X. There was positive pain on the X. There were no new areas of concern. Dr. X noted X may still X. X needed to X. X was expected to be cleared after a few more sessions of X. It was expected that the symptoms would have been gone completely already if not for having the X Forms were completed. The next appointment was anticipated in X weeks and would hopefully clear then. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: There is insufficient objective information presented for review. It is understood X suffered a right shoulder injury at work. it is unclear how many X. The most recent X progress note from X indicates X was discharged from care. However, there is also a referral to X. There are no clinic notes, diagnostic studies, or response to medications identified. The official disability guidelines and Worker's Compensation guidelines have been reviewed. The guidelines do not support X. There are X. Therefore this request is not medically necessary. "Per a utilization review partial approval letter by X, MD, dated X, the request for X was denied with the following rationale: "All available clinical information has been reviewed. It is understood X suffered a right shoulder injury at

work. X has attended X. The most recent visit was X. X has not had any MRI or x-ray studies. The official disability guidelines and Worker's Compensation guidelines have been reviewed. The guidelines will X. The treating provider was agreeable to a partial modification. Therefore this request will be modified to allow X. Thereafter, X will follow-up with X treating physician. "Per a utilization review worksheet dated X, the request for X was denied with the following rationale: "All available clinical information has been reviewed. It is understood X suffered a right shoulder injury at work. X has attended X. The most recent visit was X. X has not had any MRI or x-ray studies. The official disability guidelines and Worker's Compensation guidelines have been reviewed. The guidelines will X. The treating provider was agreeable to a partial modification. Therefore this request will be modified to allow X. Thereafter, X will follow-up with X treating physician. Per a Peer review dated X, X, MD, opined as follows: "In review of the clinical findings following the workplace event, there is evidence to support an injury to the right shoulder limited to a sprain/strain. The claimant's exam findings were consistent with an acute right shoulder sprain/strain. No other acute injuries were noted based on clinical exam findings that would support any other related conditions for the work injury in question. As such, the injury in question extends to the right shoulder limited to a sprain/strain only. Diagnoses of X are both pre-existing conditions unrelated to the workplace event based on the available records which noted both conditions were present prior to the date of injury. Typically a sprain/strain type injury would resolve within X weeks from the date of injury. The records noted pre-existing conditions to include X. There is no evidence to support that either X were aggravated as a result of the workplace event. There is no evidence to support that either X were exacerbated as a result of the workplace event. For a right shoulder sprain/strain type injury, recommended treatment per ODG would be limited to the initial use of prescription medications such as X. Formal X would be indicated up to X sessions followed by a X. No other

formal medical treatment would be considered reasonable or necessary for this type of injury. For a right shoulder sprain/strain type injury, recommended prescription medications per ODG would be limited to the initial use of X. No other prescription medications would be supported as reasonable or necessary. No weaning would be required. At this point, the claimant could continue with X. No other formal medical treatment would be supported as reasonable or necessary. The prior medical history of X is a reasonable barrier to recovery from a sprain/strain type injury. The prior medical history of X is impacting on recovery from a sprain/strain type injury. “Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Based on the clinical information provided, the Reconsideration X is not recommended as medically necessary. The patient has been authorized for X. The request for additional 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 sufficient X. “Per ODG, X is recommended . Allow for X. In this case, patient has a chronic injury. X from X indicated the patient reported X had been feeling a lot better with the arm and shoulder. X continued to have painful twinges in muscles at times but less. X had X. On examination, extremities demonstrated X. Plan is that X may still work without restrictions. X needed to do more X. X was expected to be cleared after a few more X and awaited approval. It was expected that the symptoms would have been gone completely already if not for having the X. Treatment to date included X. Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied, as the reviewer at that time noted that the patient has been authorized for X visits to date and the request for additional X, exceptional factors should be noted. Per pre-authorization request form X indicated the patient has completed X. The current request is not medically necessary for this patient who had recently had X approved to date, and no

extenuating circumstances documented to clarify why a request which is in excess of guideline recommendations would be necessary, as this is a Texas jurisdiction case and the number of X cannot be modified without the consent of the treating provider, and as there is no evidence of an X noted, and there were X notes submitted for review to clarify to clarify how X. Non certify X.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:

Per ODG, X is recommended . Allow X. Critera are as follows : sprained shoulder/rotator cuff tear is X. In this case, patient has a chronic injury. X indicated the patient reported X had been feeling a lot better with the arm and shoulder. X continued to have painful twinges in muscles at times but less. X had X at the time and showed the same in X. On examination, extremities demonstrated X. Plan is that X may still work without X. X needed to do X. X was expected to be cleared after a few more X and awaited approval. It was expected that the symptoms would have been gone completely already if not for having the X. Treatment to date included X. Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied, as the reviewer at that time noted that the patient has been authorized for X, exceptional factors should be noted. Per pre-authorization request form X indicated the patient has completed X. The current request is not medically necessary for this patient who had recently had X would be necessary, as this is a Texas jurisdiction case and the number of X cannot be modified without the consent of the treating provider, and as there is no evidence of an X. Non certify X. X of continued 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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **PRESLEY 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 (PROVIDE A DESCRIPTION)**