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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 at work on X, while employed as a X. One of the X. The diagnosis was other specified postprocedural states; incomplete rotator cuff tear or rupture of left shoulder, not specified as traumatic; and unspecified injury of muscle, fascia and tendon of long head of biceps, unspecified arm, subsequent encounter. Per an office visit note dated X, by X, FNP, X was seen for upper extremity pain that had recently become worse. It was described as aching and "pain." It started X days ago and was still present. Symptoms were located in the area of the left shoulder. X noted the possibility of an injury in X. X reported similar symptoms previously. X had undergone a X. X stated that about a week ago, X started having increasing pain to the left shoulder that extended and radiated down through the left arm. It was believed that perhaps X had overdone it in X. The pain, however, had worsened over the previous several days and X stated X had been unable to sleep at night due to the pain. X was advised by Dr. X office as well as X PCP's office to go to the emergency department. On examination, the left shoulder revealed X. The assessment was X. X was prescribed. X was to follow-up with a Workers' Compensation doctor that day as scheduled as further evaluation was necessary. X, MD evaluated X on X when X presented for evaluation of X left shoulder X on X. X was now X months out. X pain was still present and X had a significant amount of X. X could not raise the shoulder on X own above X degrees. Passively they could get X higher. X was denied further X. Left upper extremity examination revealed a X, and X. The assessment was acute pain of left shoulder. Dr. X was happy X had not developed a X. It was imperative to continue X. It was imperative to continue. The plan was to order a new prescription and see X back in X weeks. X was seen for a X on X by X, PT. The diagnosis was other specified postprocedural states; incomplete rotator cuff tear or rupture of left shoulder, not specified as traumatic; and unspecified injury of muscle, fascia and tendon of long head of biceps, unspecified arm, subsequent encounter. X reported continued left shoulder pain. X was not able to

sleep at night secondary to left shoulder pain. X had limits with left shoulder elevation overhead and reaching behind X back. X was unable to perform self as X did prior to X injury. X was a X. X rated the pain X. X was X. The left shoulder pain was described as X. It was constant, X at rest, X with activity, and the worse pain level was X and least pain level was X. Lifting, reaching behind the back, and reaching away from the body exacerbated the pain. Medication and rest relieved it. The X score was X. On examination, there was moderate tenderness to palpation in the left anterior shoulder. Active range of motion (AROM) of the left shoulder revealed flexion X degrees with X strength, abduction X degrees with X strength, internal rotation X degrees with X strength, and external rotation X degrees with X strength. Diagnostic clusters for impingement showed a positive test on the "right." X had good potential to reach the established goals. X was recommended X. The planned interventions included X. X was to begin with X. X was unable to have cold or heat at the time per 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 ODG supports up to X. The ODG would X. In this case, the worker underwent a left shoulder rotator cuff repair on X. Previous reviews suggest that at least X visits of X were completed; however, there is a recent X. There are X. There also was X. Based on the available information, X is not medically necessary. Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD with the following rationale, "The ODG by MCG recommends up to X. The guidelines do X. In this case, the request was previously denied on X. A physical therapy evaluation from X by X, X indicates that the worker has X. Pain is rated as X. The worker underwent a X. The examination revealed a X. The provider requested X. Unfortunately, there is no indication of completion of X. In addition, there is no support for X. Therefore, the request for X, is recommended for noncertification. "The requested X are not medically necessary. According to the medical records, the patient has already completed X. X is not supported by the guidelines. In addition, X are not supported by the guidelines. No new information has been provided which would overturn the previous denials. 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 are not medically necessary. According to the medical records,

the patient has X. X is not supported by the guidelines. In addition, X are not supported by the guidelines. No new information has been provided which would overturn the previous denials. 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