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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X

IRO CASE #:

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 with a date of injury of X. While X from the X. The X sustained a X. The diagnoses were pain in unspecified shoulder, unspecified fracture of upper end of left humerus, subsequent encounter for fracture with routine healing. X was seen by X, MD on X for a follow-up. X had undergone X since X prior visit. X had very little in the way of pain, doing well, and felt that X continued to make good strides in X range of motion and strength, although not quite what these were prior to X. To review, X did complete a X on X, with the recommendation of additional X. Of note, they noted that X performed at a level adequate enough to be at X job restrictions / requirements. The pain score was X at the time. X had a history of X. X had X but worked part-time as a X. On examination of the left shoulder, there was no pain with rotation motion with the arm at the side. Range of motion revealed active X of X degrees, passive X of X degrees, passive X of X degrees, and active X of X. X strength was X.

X-rays of the left shoulder showed X. The assessment was X. X was doing very well. At the time, X was healed and X had made good progress. X was free from any restrictions. Treatment plan was to continue X. X underwent a physical therapy session by X, PT on X for complaints of the left shoulder. X reported that X could see improvement in the left shoulder but continued to have X. On examination of the left shoulder, range of motion revealed forward flexion of X degrees (X degrees at re-evaluation), external rotation of X degrees, internal rotation of X degrees X (degrees at re-evaluation), and abduction of X degrees (X degrees at re-evaluation). Passive range of motion showed X degrees of forward flexion. Strength was X with abduction; flexion of X; and abduction of X. Left mid trapezius and lower trapezius strength was X on reevaluation. Scapular assist test was X. Per assessment, X had difficulty X. X noted improved left shoulder active range of motion. The assessment included X. Treatment plan was to X. Treatment to date included X. Per a utilization review adverse determination letter dated X; the request for X was denied by X, MD. Rationale:

“Based upon the medical documentation presently available for pain, Official Disability Guidelines would not support a medical necessity for this specific request as submitted. It is documented that previous treatment has included access to an extensive amount of treatment in the form of supervised rehabilitation services. The requested amount of treatment in the form of supervised rehabilitation services would exceed what would be supported per criteria set forth by the above-noted reference for the described medical situation. As a result, presently, medical necessity for this specific request as submitted is not established”. Per a utilization review adverse determination letter dated X; the prior denial was upheld by X, MD. Rationale: “Based on the documentation provided, the claimant has been recommended for X. This is a

reconsideration. The prior request was denied by X, MD for exceeding treatment guidelines. The claimant is a X that was injured on X while X. The claimant sustained a X. On X, the claimant presented to X, PT. The claimant reported improvement in X left shoulder but X still had X. Examination of the left shoulder revealed active forward flexion X, external rotation X, internal rotation X, abduction X. Positive scapular assist, mid trap X, lower trap X. In this case, the claimant has had X. The benefit of further X at this time has not been established. The number of visits has exceeded guidelines and there is no rationale or contraindication that a X would not be sufficient enough to address any remaining deficits. X for a claimant whose condition is neither regressing nor improving is considered not medically necessary. Medical necessity cannot be established for X for Left Shoulder X." The requested X is not medically necessary as the request would exceed the recommended guidelines. The patient should be well versed on a X. The patient is approaching X year from the date of injury. No new information has been provided which would warrant the current request and supersede the recommended guidelines. X for Left Shoulder X are 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 as the request would exceed the recommended guidelines.

The patient should be well versed on a X. The patient is approaching X year from the date of injury. No new information has been provided which would warrant the current request and supersede the recommended guidelines. X are 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