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Notice of Independent Review Decision
Amendment X
Amendment X

IRO REVIEWER REPORT
Date: X ; Amendment 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 reported an X. The diagnosis was superior labrum anterior-to-posterior (SLAP) tear of left shoulder. On X, X was seen by X, MD for post-operative follow-up visit. X was

status post left rotator cuff repair (RCR) and subacromial decompression (SAD) on X. X reported X. The physical exam of the left shoulder revealed X. X was neurovascularly intact distally. Active range of motion (AROM) was X degrees with forward flexion (FF X degrees and abduction X degrees. The remainder of the exam was unremarkable. An MRI showed X. The diagnosis included status post left rotator cuff repair. The plan included X. Other recommendations included X. On X, X was evaluated by X, X initial evaluation. X presented to X. X had attempted X. X underwent X in X. X attended X. X continued to present with pain and limited AROM due to pain / apprehension. The pain was rated X at best and X at worse. X required X. X disability/symptom score was X. On left shoulder examination, flexion and abduction was unable to be assessed due to pain. Muscle testing showed X. The pre-treatment range of motion showed X degrees of flexion, X degrees of abduction, X degrees of external rotation, X degrees of internal rotation, and there was a X. The remainder of the exam was unremarkable. Functional tests, return to participation, and occupational tests were unable to be assessed due to pain levels and time constraint. It was noted that X required X. Overall rehabilitation potential was X. The diagnosis included a superior glenoid labrum lesion of the left shoulder. The treatment plan included 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 claimant received extensive prior care (X), i.e., treatment in excess of the X. ODG further stipulates that the frequency of treatment should be tapered or faded over time, so as to facilitate a claimant's transition to an X. ODG further stipulates in its X. Here, however, the request for X. It is unclear why the claimant is X. Here, significant X. X remain problematic. The treating provider reported on X, that prior X." The claimant remains X. All of the foregoing, taken together, suggests that the claimant has either X. Additional treatment is unlikely to be beneficial here. Therefore, the request for X is not medically necessary”. Per a reconsideration review adverse determination letter dated X by X, the appeal request for X was denied. Rationale: “As per ODG guidelines, " X. ODG Criteria ODG X.X ." In this case, the issue here is that the claimant had shoulder surgery on X, more than X months ago. There is no information about the prior X. Given this paucity of information, the request for Appeal Request: X is not medically necessary. “Thoroughly reviewed provided records. Patient had an injury roughly X year prior and surgery over X months prior to request for X. In addition, noted to have had at least X. Though patient continues to report significant pain (X), and has functional deficits, it is unlikely

that further X. Though with typical recovery, patient would be in final phases of recovery by roughly X. However, given patients current subjective complaints and objective findings, it does not appear patient has 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:

The patient had an injury roughly x year prior and surgery over x months prior to request for X. In addition, noted to have had at least X. Though patients continue to report significant pain (X), and has functional deficits, it is unlikely that X. Though with typical recovery, patient would be in final phases of recovery by roughly X. However, given patients current subjective complaints and objective findings, X. X for the 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)**