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Notice of Independent Review Decision

Amendment

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 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 worked as a X. The diagnoses were traumatic incomplete tear of left rotator cuff, initial encounter (X) and effusion of left shoulder joint (X).On X, X was evaluated by X, MD for left shoulder pain for one month. The pain was localized laterally. The pain was maximum after strenuous activity and at night. The pain interfered with sleep and was moderate to severe. X had increased pain with overhead activity, when reaching behind X back, when laying on the shoulder at night, reaching for seat belt and putting on cloths. X did not have any prior treatment. On examination, weight was 192 pounds and BMI was 30.07 kg/m2. Left shoulder examination revealed tenderness over biceps tendon. There was X. The X was limited secondary to pain. The x-rays of the left shoulder at the time of visit revealed X. Per the review dated X by X, MD, X diagnosis was X. The physical examination of the left shoulder noted a decrease in range of motion including flexion X degrees, extension X degrees, and abduction X degrees. There was tenderness to palpation. No other specific findings or X were reported. With regard to specific diagnoses that the alleged work-related incident was a substantial factor in bringing about, without which such conditions would not have occurred, X stated that when considering the reported mechanism of injury of X. Regarding treatment, X opined, based on the most recent clinical record, ii would appear that X was being referred for an orthopedic surgery consultation. While understanding there were X. What was not presented was any specific clinical data suggesting a surgical lesion existed relative to the left shoulder. Therefore, there was no clear clinical indication for the need of an orthopedic consultation

and there was no indication for any surgical intervention based on the MRI reported. The provider noted that regarding the injury sustained, noting the specific parameters identified in the Official Disability Guidelines, no further treatment would be considered reasonably required to address the sequelae of the compensable event. Understanding this individual sustained a X. It was also noted there are X. Therefore, no additional treatment was warranted, and any X. On X, X was evaluated by X for a follow-up on left shoulder pain. X rated X pain as X. The pain was described as acing. It was worsened with certain ROM. It was aggravated by laying down, elevation, and activity. X stated X. X reported X was ready for surgery. X reported that X condition had not improved and X continued to experience significant discomfort, particurly at night. X was unable to work due to X symptoms and had been taking it one day at a time. X had not received any treatment. X was previously informed about the possibility of surgery, but it was denied. Left shoulder examination revealed X. The ROM revealed flexion to about X degrees before experiencing pain; abduction was almost to X degrees with pain; external rotation about 40 degrees; internal rotation on the left to X upper lumbar spine; and internal rotation on the right was to X mid thoracic spine. There was some giveaway weakness seen on the left. Dr. X explained that the MRI demonstrated a X. X was explained that even with X. An MRI of the left shoulder dated X showed X. Treatment to date included X. Per the utilization review dated X by X, MD, the request for X was denied. Rationale: “Per ODG criteria for surgery includes, "X" In this case, the patient has decreased range of motion and pain. X has been treated with activity modification. MRI showed X. Prominent complicated X.X. Mild to X.X.X. Mildly X. However, there is no evidence of X. Therefore, X is not medically necessary and is not certified.” Per utilization review report dated X by X, MD, the request for X was denied. Rationale: “For a X, the ODG requires a trial of nonsurgical treatment to include X No X was completed in this case. Therefore the request for X is not medically necessary. The requested

surgical procedure is not medically necessary. Based on the submitted medical records, the patient has X. 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 is not medically necessary. Based on the submitted medical records, the patient has X. 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