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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 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 in a X. X was on a ladder approximately X. The diagnosis was closed displaced fracture of shaft of left clavicle with routine healing, subsequent encounter (X). On X, X was seen by X, MD for a follow-up visit of X. X had rib fractures. X had been treated conservatively for X left clavicle. X had not been doing well with conservative management. On examination, X weight was 140 pounds and body mass index (BMI) was 24.03 kg/m2. Musculoskeletal examination revealed tenderness. Left shoulder examination revealed tenderness in the clavicle. Range of motion was abnormal in all planes. An x-ray of left clavicle dated X showed healing clavicle fracture. X had left clavicle fracture that had not been doing well with conservative management and was causing symptomatic issues. X fracture showed gapping. On X, X was seen by Dr. X for a follow-up visit for left clavicle with x-rays. X reported that the injury was causing significant dysfunction of the shoulder which included popping, catching, and locking. X had been in therapy since X. It was a chronic problem. The ongoing episode started more than one month prior. The problem occurred constantly. The pain occurred in the context of an injury. The pain was present in the left shoulder. The pain was severe. The symptoms were aggravated by any movement and exercise. Associated symptoms included joint swelling and stiffness. Left shoulder examination revealed tenderness in the clavicle. Range of motion was abnormal in all planes. Prominence of the clavicle seen. There was fracture mobility seen. X had left clavicle nonunion. X had failed conservative management which included at least X. X reported that it was causing significant catching, locking, and popping. There was fracture mobility seen. X was concerned for nonunion. There was at least X cm of shortening as well. Surgical treatment for left clavicle X was reconsidered. Treatment to date included X. Per the utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Per the submitted documentation, the request is not warranted. The claimant had a left clavicle fracture and rib fractures, which were not doing well with conservative management. There was X. A repeat x-ray was done and independently reviewed and interpreted on X, which resulted in a healing clavicle fracture. The referenced guideline states that X is not recommended except in rare cases, such as when the X. The request is medically necessary based on the claimant’s clinical presentation

to be able to address their pain. However, it was not clearly documented in the objective findings, if there was X. In addition, a repeat x-ray resulted in a healing clavicle fracture. Therefore, the prospective request for X is non-certified. “Per the utilization review dated X by X, MD, the request for X was denied. Rationale: ”Regarding the request for X. It emphasized that although X improved the odds of bone healing, that the need for secondary operations is considerable, and that surgery did not improve shoulder function, general symptoms, or decrease limitations over sling treatment. Proceeding with the request for X is not indicated. Although the medicals showed that the claimant has severe left shoulder pain and has failed to improve after X months of conservative treatment, x-rays were reported to show a healing clavicle fracture without note of displacement or malunion. Therefore, the appeal request for X is non-certified Per the utilization review dated X by X, MD, the request for X was denied. Rationale:” Regarding the request for X. It emphasized that although X improved the odds of bone healing, that the need for secondary operations is considerable, and that surgery did not improve shoulder function, general symptoms, or decrease limitations over sling treatment. Proceeding with the request for X is indicated. The medicals showed that the claimant has severe left shoulder pain and has failed to improve after over X months of conservative treatment, x-rays were reported to show a X. The prospective request for X is medically necessary and certified

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Per the utilization review dated X by X, MD, the request for X was denied. Rationale:” Regarding the request for X. It emphasized that although X improved the odds of bone healing, that the need for secondary operations is considerable, and that surgery did not improve shoulder function, general symptoms, or decrease limitations over sling treatment. Proceeding with the request for X is indicated. The medicals showed that the claimant has severe left shoulder pain and has failed to improve after over X months of conservative treatment, x-rays were reported to show a X. The prospective request for X is medically necessary and certified
Overturned

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)**