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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 sustained an injury on X. X fell on a wet sidewalk, injuring X lower back, left knee, and right shoulder. The diagnoses included adhesive capsulitis of right shoulder, traumatic right rotator cuff tear, and biceps tendinitis of right upper extremity. X was seen by X, MD on X for right shoulder postop follow-up. X was X, X. X was status X, X. X had been working diligently with therapy; however, X had plateaued with X range of motion. Right shoulder range of motion revealed active abduction X degrees, passive abduction X degrees, external rotation X degrees, forward flexion X degrees, and internal rotation X degrees (sacrum). Incision was healing well without any erythema, fluctuance, or drainage. Sensation was intact to axillary, median, ulnar, and radial nerves. Left knee examination revealed mild swelling, effusion, tenderness over medial joint line, and normal range of motion. It was noted that X redeveloped adhesive capsulitis of X shoulder again. X had difficult situation in which X had rotator cuff repair as well as capsular release. X was recommended. X, X presented for a follow-up of right shoulder pain. X went to therapy on X and reinjured after an aggressive session. X then had X on X. X complained of increased amount of pain. X had X on the prior visit on X. X was slowly improving. X body mass index was 41.81 kg/m^2. Right shoulder range of motion revealed active abduction X degrees, passive abduction X degrees, external rotation X degrees, forward flexion X degrees, and internal rotation X degrees (sacrum). X were X. X was healing well without any X. X was X. Left knee examination revealed X. Treatment to date included X. Per Notice of Adverse Determination - WC Network Utilization Review by X, MD on X, the request for X was non-certified. Rationale: “ODG by MCG, X: X, "Recommended as indicated below, only for primary X.

Poorer X. 1. Conservative Care: X. "Based on the provided documentation, the patient is status X. Physical examination revealed significantly limited range of motion; active abduction X degrees, passive abduction X degrees, external rotation X degrees, forward flexion X degrees, and internal rotation X degrees. It is noted that X is intact to X. The patient is able to X. X is also X. The claimant has been treated with X. Criteria has not been met. Additional information is needed in order to ascertain the necessity of this request. Therefore, medical necessity has not been established and this request is non-certified. “Per Notice of Appeal Adverse Determination WC Network by X, MD on X, the request for X was non-certified. Rationale: “Guidelines require X. Therefore, the request for X is not medically necessary. “The requested surgical procedure is not medically necessary. The submitted medical records do not demonstrate that the patient has attempted at X. The patient surgery was on X and therefore at X. No new information was provided which would overturn the previous denial. 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 surgical procedure is not medically necessary. The submitted medical records do not demonstrate that the patient has attempted X. The patient surgery was on X and therefore at X. No new information was provided which would overturn the previous denial. 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)**