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Notice of Independent Review Decision

Amendment X

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 reported X tripped over a panel sticking out of the wall and

X fell forward with the right arm up while working as a X. The diagnosis was right knee sprain, strain of right knee, sprain of right shoulder, right shoulder strain, impingement syndrome of right shoulder, and adhesive capsulitis of right shoulder. On X, X visited X, PA-C /X, MD for a follow up for traumatic right rotator cuff tear evaluated on X and right knee pain. X was following up for pain in X right shoulder. X was seen on X, at which time surgery was discussed. X stated X continued to be hesitant to proceed with the rotator cuff repair surgery that was recommended. X was doing daily homes exercises and stretches to maintain X range of motion in X elbow. X was unable to do any overhead reaching. The pain in X shoulder radiated to X right upper arm. X described it as a sharp shooting pain with occasional numbness and tingling in all of X fingers. X pain level was a X. X also presented for an initial evaluation for right knee pain. X symptoms began as a result of an injury at work on X. X tripped on wall panel and fell forward. X landed on X right knee. Since then, X completed X sessions of physical therapy with little improvement. X had a right knee MRI on X. X reported X had a second MRI, but X did not recall the name of the facility. X had a cortisone injection performed by Dr X on X without any noticeable improvement. Since then, the focus on X treatment had been X right shoulder. X was doing daily home exercises and stretches with little improvement. X complained of popping that was occasionally painful. The pain increased with cold weather. X pain level was a X. On examination, X blood pressure was 107/73 mmHg, weight was 225 pounds and body mass index (BMI) was 37.4 kg/m2. X had mild antalgic gait and limping on the right side. Right shoulder range of motion revealed forward flexion to X degrees with pain, abduction to X degrees with pain, external rotation to X degrees with pain, and internal rotation was with pain and posterior superior iliac spine (PSIS). There was tenderness to palpation in the subacromial space. Shoulder abduction and internal rotation strength was X. Right shoulder was guarded. X were X. X was weak. Right knee range of motion revealed flexion to X degrees, limited with pain and extension to X degrees. There was X. Strength in the right quadriceps was X. X were X. The assessment included X. Right MR arthrogram was recommended. X was to follow-up in four weeks. X was seen by X, FNP-C on X for a follow up for a work-related injury which occurred on X. X stated that while working during the normal course and scope of X employment with X, X was employed as a X. X reported X tripped over a X. After the fall. X started having right shoulder and right knee pain. X was taken to X. X underwent x-rays of the knee and the shoulder. X was prescribed medications and was subsequently discharged. X was then evaluated at a clinic one time. X then came under the care of X. X underwent a course of therapy. X was

referred for shoulder and knee MRI. After the MRIs, X was referred to Dr. X. Dr. X provided X which did not help with the pain. Benefit dispute agreement stated party agreed the compensable injury of X extended to and included a X. Dr. X then recommended right shoulder surgery. X underwent right shoulder surgery on X. X attended postsurgical therapy. X then underwent shoulder MIRI and report was not available. X was evaluated by another orthopedic surgeon for a second opinion regarding the shoulder and X recommended shoulder surgery and X would possibly need shoulder replacement as well. X was then evaluated by orthopedic surgeon and X discussed shoulder surgery. X was evaluated by orthopedic surgeon regarding the knee and X recommended therapy. X stated the therapy was denied. X was evaluated by a designated doctor on X and was found to be at clinical maximum medical impairment (MMI) as of X with X impairment rating for certification number X and X. Extent of injury did not extend to include X. Decision order stated X reached maximum medical improvement on X with X impairment rating (IR). Due to the nature and severity of X symptoms. X presented to the office for evaluation and management of X condition. X was examined and recommended evaluation with orthopedic: surgeon. X was evaluated by Dr. X on X and per X, X recommended X. Per X, the X was denied by the carrier. The right shoulder MRI on X showed X. There was X. There was X. There was X. There was X. X was re-evaluated by Dr. X on X and per X, X recommended shoulder surgery. X was evaluated by designated doctor on X and stated X could can work with restrictions from X. X was approved for X. X was re-evaluated by Dr. X on X for X. On X, X indicated not wanting to proceed with surgery. On X, X reported pending follow-up with Dr. X for consideration of X shoulder procedure and evaluation of X right knee. X was re-evaluated by Dr. X on X. On X, X reported that Dr. X prescribed surgery for X right shoulder. X was re-evaluated by Dr. X on X and X recommended X. X was to consider scheduling X. The X was denied once and was pending reconsideration. X reported persistent right shoulder and right knee pain. X stated of popping of knee. Examination of the right shoulder revealed X. There was X. X of motion were restricted with pain. There was weakness of the right shoulder. Examination of the right knee revealed X. There was tenderness of the X. X provoked pain. X provoked knee joint pain. There was weakness of the right knee. The assessment included X. X had pending follow-up with Dr.X. X had pending reconsideration for X which was recommended by Dr.X. X was to work with restrictions due to functional deficits. Treatment to date included X. Per an initial adverse determination letter dated X by X, MD, the requests X was denied. Rationale: “Based on review of the provided documentation, request received for X.

History of various treatments to right knee since injury on X; right knee pain-complaining of popping occasionally painful, pain level X,X. Impression: Internal derangement, right knee, right knee sprain. Per ODG, MRI of Knee and Leg Conditions: X may be indicated by X or more of the following: Pain, chronic, localized to the knee, and ALL of the following: X. No imaging studies nor documentation of suspected X. Diagnoses include Sprain of unspecified site of right knee; Strain of unspecified muscle(s) and tendon(s) at lower leg level, right leg. Submitted documentation does not meet ODG criteria as option for treatment and does not establish medical necessity. The request for X is non-authorized. “Per appeal letter dated X by X, MD, a reconsideration request for X was made. X sustained a right knee injury as a result of a fall, which occurred on X. On X , right knee MRI demonstrated X. On X Dr. X, the orthopedic surgeon, noted that X had completed X provided by Dr. X with limited benefit. X presented with X. X recommended X to identify occult pathology not identified on the MRI study. The study was medically necessary to identify internal derangement noted on the clinical examination. Per ODG, X is indicated for chronic localized knee pain and suspected meniscus injury. Given X. X was made medically necessary as a direct result of the X injury. Dr. X appeal the carrier's denial and request authorization of the study as recommended by X orthopedic surgeon, Dr.X. Per a reconsideration adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “At the present time, for the described medical situation, Official Disability Guidelines would not support a medical necessity for this specific request as submitted. The date of injury is over X years and age. The submitted clinical documentation does not identify the presence of a significant new change on the physical examination of the affected knee compared to previous to support a medical necessity for this specific request as submitted. As a result, based upon the medical documentation presently available for review, medical necessity for this specific request as submitted is not established. “Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous non-certifications are upheld. Per an initial adverse determination letter dated X by X, MD, the requests for X was denied. Rationale: “Based on review of the provided documentation, request received for X . Diagnoses include Sprain of unspecified site of right knee; Strain of unspecified muscle(s) and tendon(s) at lower leg level, right leg. History of various treatments to right knee since injury on X; right knee pain-complaining of popping occasionally painful, pain level X,X. Per ODG,X: Pain, chronic, localized to the knee, and ALL of the following: X. No imaging studies nor documentation of suspected X. Diagnoses

include Sprain of unspecified site of right knee; Strain of unspecified muscle(s) and tendon(s) at lower leg level, right leg. Submitted documentation does not meet ODG criteria as option for treatment and does not establish medical necessity. The request for X is non-authorized." Per a reconsideration adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "At the present time, for the described medical situation, Official Disability Guidelines would not support a medical necessity for this specific request as submitted. The date of injury is over X years and age. The submitted clinical documentation does not identify the presence of a significant new change on the physical examination of the affected knee compared to previous to support a medical necessity for this specific request as submitted. As a result, based upon the medical documentation presently available for review, medical necessity for this specific request as submitted is not established." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient reportedly underwent a second knee MRI after the X study; however, this report is not submitted for review. There is no updated radiographic report of the knee submitted for review. It is unclear when the patient most recently received any form of treatment for the knee. It is unclear if there has been a significant change in the patient's clinical presentation. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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:

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous non-certifications are upheld. Per an initial adverse determination letter dated X by X, MD, the requests for X was denied. Rationale: "Based on review of the provided documentation, request received for X. Diagnoses include Sprain of unspecified site of right knee; Strain of unspecified muscle(s) and tendon(s) at lower leg level, right leg. History of various treatments to right knee since injury on X; right knee pain-complaining of popping occasionally painful, pain level X, X. Per ODG, MRI of Knee and Leg Conditions: X: X. No imaging studies nor documentation of X. Diagnoses include Sprain of unspecified site of right knee; Strain of unspecified muscle(s) and tendon(s) at lower leg level, right leg. Submitted documentation does not meet ODG criteria as option for treatment and does not establish medical necessity. The request for X is non-authorized." Per a

reconsideration adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “At the present time, for the described medical situation, Official Disability Guidelines would not support a medical necessity for this specific request as submitted. The date of injury is over X years and age. The submitted clinical documentation does not identify the presence of a significant new change on the physical examination of the affected knee compared to previous to support a medical necessity for this specific request as submitted. As a result, based upon the medical documentation presently available for review, medical necessity for this specific request as submitted is not established.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient reportedly underwent a second knee MRI after the X study; however, this report is not submitted for review. There is no updated radiographic report of the knee submitted for review. It is unclear when the patient most recently received any form of treatment for the knee. It is unclear if there has been a significant change in the patient’s clinical presentation. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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