True Decisions Inc.
An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #615
Mansfield, TX 76063
Phone: (512) 298-4786
Fax: (888) 507-6912
Email: @truedecisionsiro.com

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 had a X. The diagnoses were right shoulder pain and sprain / strain of rotator cuff tear (RTC) of right. On X, X was evaluated by X, X initial evaluation. X was referred by and X, MD. The diagnoses were right shoulder pain and sprain / strain of rotator cuff tear (RTC) of right. X presented with complaints of right shoulder pain and strain of muscles of rotator cuff. At the time, X complained of decreased range of motion (ROM), strength, flexibility and increased pain. These deficits limited X ability to perform these tasks: lifting from floor, lifting overhead, reaching forward, reaching overhead. Prior to injury, X worked as a X which required a PDL of light: X to X pounds. X would be benefited from X. X reported that X had a X. This resulted in a tear of X rotator cuff. X did X. X noticed some increase in shoulder pain in X and X. X pain had gradually gotten worse over the past several weeks. Regarding functional capabilities, the material handling included as from floor to waist was X pounds; above shoulder X pounds; carry from right / left was X pounds. Physical examination revealed active / passive range of motion (ROM) of right and left shoulder flexion was X / X degrees, and abduction was X / X degrees. Manual muscle strength in bilateral shoulder flexion (X), bilateral internal rotation (X), and bilateral external rotation (X) was X; and right shoulder abduction (X) was X. There was X noted with overhead movements on the right. There was X compensation noted. X were positive on the right. Trace reduced X was noted. On assessment, X was advised for X. Treatment to date included X. Per a utilization review worksheet dated X, a Notice of Dispute dated X was documented. It was stated that the compensable injury did not extend to or include:• Right shoulder X The evidence-based medical records and other information do not demonstrate that the injury of X was a producing cause of the claimed conditions. We dispute these findings are related to or a part of the work related injury, as they are either pre-existing conditions, ordinary diseases of life and / or all did not occur within the course and scope of your employment. “Workers' Compensation benefits would be

continued as related to the compensable injury. Dr. X, MD has reviewed your medical records and opined in a report dated X that the diagnoses listed above are not related to or caused by the compensable injury. “Per a utilization review adverse determination letter dated X by X, DPM, the request for X was denied. Rationale: “This request is for a X who reported experiencing right shoulder pain on X, MOI unspecified). X reevaluation on X, after X visits, documented increased ROM and strength relative to the X baseline evaluation (active right shoulder flexion increased to X degrees, but abduction decreased from X). After careful review it is noted that there is not enough supporting documentation for this request. There is not enough supporting clinical documentation warranting approval of this request. “Per a utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: “The ODG supports up to X. In this case, a request has been received for X. There are no clinical documents to establish the medical necessity of the request. As such, X is recommended for noncertification. Thoroughly reviewed provided records including peer review. Noted by X that patient had increased range of motion and overall functional improvement from prior X , thus further X were requested. Request is reasonable but there were some questions about compensability, and the cited guidelines allowed for X. Regardless, discounting latest reevaluation, the patient should still be able to have X. X medically necessary and certified.

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

Thoroughly reviewed provided records including peer review. Noted by X that patient had increased range of motion and overall functional improvement from prior X were requested. Request is reasonable but there were some questions about compensability, and the cited guidelines allowed for X. Regardless, discounting latest reevaluation, the patient

should still be able to have X. X medically necessary and certified.
Partially 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

☐ 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