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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. The mechanism of injury was not provided in given medical records. The diagnoses were other specific arthropathies, not elsewhere classified, right shoulder; failure of previous rotator cuff repair and ganglion cyst.

On X, X was evaluated by X, MD for a follow-up of post-operative right shoulder stiffness (SS). X was status post right rotator cuff tear repair in X and superior capsular reconstruction (SCR) of right shoulder on X. X had X given on X. X had an upcoming surgery for X left shoulder. Therefore, X wanted to X. On examination, weight was 220 pounds and body mass index (BMI) was 31.56 kg/m2. No physical examination is available in the report. Treatment plan was X.

An MRI of the right shoulder dated X revealed X. There was a X. X was seen. Non visualization of the X was noted. Faint nonspecific edema in the X was present.

Treatment to date included X.

Per the utilization review dated X by X, MD, the request for X was denied. Rationale: “Per the submitted documentation, the request is not warranted. The referenced guideline recommends repeat X. A prior request with the most recent one under X was certified on X to address the pain, increase functionality, and improve the quality of life. The claimant wanted X. Imaging findings showed a X. The request is not medically necessary based on lack of subjective and objective findings that would support the necessity for X. There were no worsening symptoms nor documentation of an improvement from X on X.

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: "A prior request for X was certified on X to address the pain, increase functionality, and improve the quality of life. It appears that the prior non-certification is appropriate. The claimant was being considered for X. The provider would like to have X. The cited guideline supports X. Since there was no evidence whether X. Given the above information; therefore, the appeal request for X is non-certified."

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per the utilization review dated X by X, MD, the request for X was denied. Rationale: "Per the submitted documentation, the request is not warranted. The referenced guideline recommends X. A prior request with the most recent one under X was certified on X to address the pain, increase functionality, and improve the quality of life. The claimant X. Imaging findings showed a X. The request is not medically necessary based on lack of subjective and objective findings that would support the necessity for X. There were no worsening symptoms nor documentation of an improvement from X on X. Therefore, the prospective request X is non-certified." Per the utilization review dated X by X, MD, the request for X was denied. Rationale: "A prior request for X was certified on X to address the pain, increase functionality, and improve the quality of life. It appears that the prior non-certification is appropriate. The claimant was being considered for X. The provider would like to have X. The cited guideline supports X. Since there was no evidence whether the X. Given the above information; therefore, the appeal request for X is non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines note that, "With several months of temporary, partial resolution of symptoms, and then

worsening pain and function, a X." There is no information provided regarding this patient's response to the X. There is no information regarding percentage and duration of pain relief, increased functionality and/or decreased medication usage. 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 denials are upheld. Per the utilization review dated X by X, MD, the request for X was denied. Rationale: "Per the submitted documentation, the request is not warranted. The referenced guideline recommends X. A prior request with the most recent one under X was certified on X to address the pain, increase functionality, and improve the quality of life. The claimant wanted X. Imaging findings showed a X. The request is not medically necessary based on lack of subjective and objective findings that would support the necessity for X. There were no worsening symptoms nor documentation of an improvement from X. 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: "A prior request for X was certified on X to address the pain, increase functionality, and improve the quality of life. It appears that the prior non-certification is appropriate. The claimant was being considered for X. The provider would like to have X. The cited guideline supports X. Since there was no evidence whether the X is still not supported. Given the above information; therefore, the appeal request for X is non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The

Official Disability Guidelines note that, “With several months of temporary, partial resolution of symptoms, and then worsening pain and function, a X.” There is no information provided regarding this patient’s response to the X. There is no information regarding percentage and duration of pain relief, increased functionality and/or decreased medication usage. 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:

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE