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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: 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:

☐ Upheld (Agree)

☒ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

This case concerns a X who has requested authorization and coverage for X. The Carrier denied this request on the basis that these services are not medically necessary for treatment of the member's condition.

A progress noted dated X indicated that the member presented for right shoulder pain. It noted that the member works as a X. It indicated that the member's symptoms began on X after X. It noted that the member felt a tearing sensation at that time and noted weakness and pain with any attempted overhead motion. It indicated that the location of the pain is generally X. It noted that the member described X discomfort as a dull/achy pain, which is unchanging with time. It indicated that the member has taken X. It noted that the pain is improved by X. It indicated that it worsened by X. It noted that the member's symptoms prevent X from X. It indicated that the member has no problems on the contralateral side. It noted that the member also describes weakness with forward elevation. It indicated that work-up/treatment to date has included magnetic resonance imaging (MRI). It noted that the images from the MRI taken and envision imaging on X were reviewed and discussed with the member. It indicated that the member has a X. It noted that there is X noted. It indicated that there is X.

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

The Maximus physician consultant noted that a review of records indicated the member was being X. Past medical history was positive for

X. Past surgical history was X. Conservative treatment included X. The X magnetic resonance imaging of the right shoulder has X.

The Maximus physician consultant noted that the X treating physician report cited X. The member noted X. The right shoulder examination revealed X. There was X. Range of motion was X. Strength was X out of X in forward elevation. Drop arm, Neer's, Hawkin's, Speed's, and O'Brien's were all X. The treatment plan included X.

The Maximus physician consultant indicated that as per Official Disability Guidelines (ODG), "X.

The Maximus physician consultant noted that in this case, the member had persistent pain that was constant with activity with X. This was corroborated by objective findings of 3 out of 5 strength in forward elevation. Additionally, the X magnetic resonance imaging of the right shoulder had X,X. This was an acute injury with the member's symptoms beginning on X.

Therefore, the requested X is medically necessary for the treatment of the member's condition.

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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES.**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES:**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE**

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