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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 Overturned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was X. The diagnosis was pain in femur, gunshot wound of right shoulder region, open fracture of shaft of left femur, and right biceps tendinitis.

On X, X was evaluated by X, PA-C for follow-up of open fracture of shaft of left femur and gunshot wound of the right shoulder region. X was status post retrograde intramedullary nailing left femur plus excisional debridement of right shoulder wound by Dr. X on X. X presented walking without assistive device. The leg felt stronger. X reported more muscle soreness, which X attributed to being able to do more with the leg. X reported new onset right shoulder pain with certain motions like washing hair, felt a pop in the shoulder with associated pain that was relieved after a couple of seconds. There was no new injuries. X reported X had been active trying to strengthen X anterior deltoids. On examination, the right shoulder was with near-full motion. There was mild tenderness over the proximal biceps. There was X. The assessment was pain in femur, gunshot wound of right shoulder region, open fracture of shaft of left femur, and right biceps tendinitis. X had new symptoms consistent with X. X had significant X. X was recommended. If there was no improvement, an X would be considered. X was to continue light duty work restrictions as before.

Treatment to date included X.

Per a utilization review adverse determination letter and a peer review report dated X by X, MD, the request for X was denied. Rationale: “"ODG by MCG Last review/update date: X, X. Contusion of shoulder: X" The X are not medically necessary. The patient has X. X is not warranted or supported by the guidelines. Therefore, the request for X is non-certified.”

Per a peer review report by X, MD dated X, the request for appeal – X was denied

as not medically necessary. Rationale: “The claimant has recommended APPEAL - X. However, the claimant has X. There X. Therefore, the request for APPEAL - X is not medically necessary.

The request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter and a peer review report dated X by X, MD, the request for X was denied. Rationale: “"ODG by MCG Last review/update date: X, X. ODG Criteria ODG X. Contusion of shoulder: X are not medically necessary. The patient has already X. X is not warranted or supported by the guidelines. Therefore, the request for X is non-certified.”

Per a peer review report by X, MD dated X, the request for appeal X was denied as not medically necessary. Rationale: “The claimant has recommended APPEAL - X. There is X. Therefore, the request for APPEAL - X is not medically necessary. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient has X. The request for X. When X. There are X. The patient has X. 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 request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter and a peer review report dated X by X, MD, the request for X was denied. Rationale: “"ODG by MCG Last review/update date: X" The X are not medically necessary. The patient has X. Therefore, the request for X is non-certified.”

Per a peer review report by X, MD dated X, the request for X was denied as not medically necessary. Rationale: “The claimant has recommended APPEAL - X. However, the claimant has X. There is limited positive findings to warrant the need for X. Therefore, the request for APPEAL -X is not medically necessary. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient has X. The request for X. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed

recovery documented. The patient has X. 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