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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 injured on X. X was injured while X. The diagnosis was impingement syndrome of left shoulder.

On X, X had an X with X, OTR/L for left rotator cuff repair. X had X. X demonstrated improvement with pain and range of motion after injury in early X where the MRI showed and X. X demonstrated improvement with X. X was gradually X. X continued to demonstrate X. X had been educated on performance of X. X reported difficulty with reaching behind X back to wash, reaching out to retrieve items, and lifting heavier items. X reported up to X pain if X "pushes X arm too far or reaches too far." On examination of left shoulder range of motion included flexion to X degrees, abduction to X degrees, external rotation to X degrees and internal rotation to X degrees with compensation. Strength in left shoulder flexion and abduction was X. X QuickDASH score was X. X reported that since attending X, X was able to sleep on X left side better, wash X hair and perform dressing tasks better. X was recommended to X.

X attended X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “The ODG recommends up to X. The provided documentation indicates the claimant X. The provider has requested X. As such, partial certification is advised with X. However, as I was unable to reach the treating physician to discuss treatment modification, the request remains not certified at this time. Peer to peer was unsuccessful.”

Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale: “The Official Disability Guidelines would X. These X were performed on X. After X, they participated in X. Current progress notes include X. X has also X. The previous review had supported an X. This request would be X. However, as no peer has been established, this request is not certified in its entirety. Peer to peer was unsuccessful.”

The requested X is not medically necessary. The clinic records indicate that the patient has X. The guidelines only X. There are no extending circumstances which would supersede the recommended guidelines. No new information has been provided which would overturn the previous denials. As such, the X is not supported. 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 requested X is not medically necessary. The clinic records indicate that the patient has already X. The guidelines only X. There are no extending circumstances which would supersede the recommended guidelines. No new information has been provided which would overturn the previous denials. As such, the requested X is not supported. 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