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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 at work, and X had X slipped and fell and landed on X elbow. The diagnoses were rotator cuff tear, traumatic, right; acromioclavicular sprain and bicipital tendinitis.

On X, X was seen by X, MD, for initial evaluation for X right shoulder pain. X stated X injury happened about X months prior in X. X was at work, and X had X. X did slip and fall and landed on X elbow. X stated at that time X did have elbow pain, but it did go away. At the time, X had pain at the top of X shoulder and radiated down into X biceps. X said that it was more of a throbbing pain, rated X, but it could get to X. X did have a history of X. X said that it did help with X range of motion, but other than that, the pain was still there. X denied having any swelling or previous injuries to X shoulder. X had been given restrictions of no overhead activity, but X had been working full duty. X worked at X. On examination, X weight was 218 pounds and body mass index (BMI) was 28 kg/m2. On X right shoulder examination, X did have a painful arc of motion. X had tenderness at the X. X were present, but X had significant X which were noted with testing. X gave X discomfort on this right side. On the left shoulder, X had full motion without a painful arc of motion and better strength and

external rotation and belly press than X did on the right. X-rays of the right shoulder were obtained which revealed X. There was not any evidence of X. There was X. AC joint showed X. There was X noted. There was a little bit of X. An MRI of the right shoulder was reviewed which showed X. The X looked to be X. The X looked to be intact inferiorly but was removed superiorly. There was tearing of the top edge of the X was X over. There was X noted. On the X, there was a tear of the X. There was a mild amount of retraction. At the X which were noted. There was no evidence of X noted. On assessment, X had a significant X. X also had X. X also aggravated X AC joint. X had attempted X. X was recommended for an X.

An MRI of the right shoulder dated X showed X. X was noted. Mild-to-moderate X was noted. Mild X was present secondary to mild X. An X was present.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale for X: “The Official Disability Guidelines (ODG) state that X. This guideline recommends X. The claimant reportedly had an unspecified number of X. The claimant was using X. The right shoulder exam showed X. The right shoulder MRI on an undisclosed date reportedly showed X. Dr. X opined that the claimant had a significant X. The ODG recommends X. The request is not supported as a copy of the diagnostic report was not submitted to support the diagnostic findings. Also, there was no documentation

of X. The state of Texas Worker's Compensation regulations do not allow sending a request to the provider for additional information. Therefore, the request for X is non-certified." Rationale for X: "The ODG recommends X. The claimant reported right shoulder pain going down the biceps region. A right shoulder MRI from an undisclosed date reportedly showed X. The exam showed X. Dr. X opined that the claimant had a X. Per the note, the claimant had an unspecified X. The ODG recommends X. The guideline recommends X. Based on this, the request is not supported by the guidelines. In addition, there was no documentation if the claimant had an X. Also, a copy of the MRI report was not submitted to support the documented diagnostic findings and the request for the X. Therefore, the request for X is non-certified." Rationale for X: "The ODG states that criteria for X. X is indicated for X. According to Dr. X, the right shoulder x-ray showed X. The right shoulder MRI from an undisclosed date reportedly showed X. There was X. The exam showed X. Dr. X opined that the claimant had X. The request is not supported as the copy of the MRI report was not submitted to support the documented findings. Also, there was no documentation regarding X. Therefore, the request for X is non-certified."

Per an undated appeal letter by X, stated that "X. These guidelines are used for X. X has an X. The denial describes X. But again, that is not the X. The ODG guidelines for the X: Disabling pain associated with rotator cuff injury - X describes X pain at X at rest but increases to X with use. X documented on imaging studies (MRI) that correlates with symptoms - The MRI report and Dr. X review

of the MRI describes a X. Injury results in functional deficit in affected arm (unable to externally rotate against resistance) - In the X office visit with Dr. X, X physical examination showed a X. For the X, the denial states a X. However, the ODG guidelines state that a X is recommended when the X. In the X office note, Dr. X noted the X. For the open distal clavicle resection, the denial only comments on ODG guidelines regarding recommendation for a X. This is not the requested procedure. X did not sustain a shoulder dislocation. There has been no documentation regarding a shoulder dislocation, X has been diagnosed with an acromioclavicular sprain with arthrosis. The MRI report describes X. Both x-ray and MRI describe a X. It also states an X is present. On the X office note, the physical examination shows X. The X office note also shows X. X has had X. X then did X. X does take X. At this point X. The next step would be X."

Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale for X: "The Official Disability Guidelines (ODG) recommends X. The Official Disability Guidelines require that X. Based on the provider's response, the claimant stated that they were going to X. This does not meet the ODG's requirements of at X. Therefore, the requested X is non-certified." Rationale for X: "X is recommended by ODG for X, X are documented. It is indicated when history, physical examination, and imaging indicate significant X. Upon review of the submitted records, it appears that the prior non-certification was appropriate. The Official Disability Guidelines require that there be X. Based on the

provider's response, the claimant stated that they were going to X. This does not meet the ODG's requirements of at X. Additionally, ODG stated that X. Therefore, the requested X is non-certified." Rationale for X: "The Official Disability Guidelines recommends X. Objective clinical findings include X. Or X. Imaging findings X. Conservative treatment X. Upon review of the submitted records, it appears that the prior non-certification was appropriate. The Official Disability Guidelines requires that there be lack of X. Based on the provider's response, the claimant stated that they were going to X. This does not meet the ODG's requirements of at X. Therefore, the requested X is recommended non-certified."

The available records noted complaints of X. The MRI report submitted for review did note showed X. X was noted. Mild-to-moderate X was noted. While there are clinical findings noted to support consideration of X. There was X. Therefore, it is this reviewer's opinion that medical necessity for the requests is not established and the prior denials are upheld. 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 available records noted complaints of X. The MRI report submitted for review did note showed X. Mild X was noted. Mild-to-moderate X was noted. While there are clinical findings noted to support consideration of X. Therefore, it is this reviewer's

opinion that medical necessity for the requests is not established and the prior denials are upheld. 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