

I-Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 IR
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 790-2280
Email: @i-resolutions.com

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. The

biomechanics of injury is not available in the records. The diagnoses were left shoulder strain, labral tear of long head of biceps tendon of left shoulder, and superior labrum anterior-to-posterior (SLAP) tear of left shoulder. On X, X, FNP evaluated X for a follow-up of left shoulder. X had a functional capacity evaluation (FCE) and was qualified as "light" under the level of work and demonstrated and verbalized ability to tolerate X hours workday with light duty accommodations. Due to increased pain and discomfort, X had to take frequent breaks to complete tasks and was unable to lift more than X pounds. FCE recommended that X benefit from X. X had impairment rating on X showed an estimated maximum medical improvement (MMI) at X, if X. Left shoulder examination revealed there was X. There was tenderness in the anterior shoulder, but not in the superior shoulder. There was X. There was full range of motion with pain. Basically, there was full range of motion with end range discomfort. A referral for X was provided, X. Per Functional Capacity Evaluation dated X, X, PT, DPT documented that X. Due to increased pain / discomfort, X had to take frequent breaks to complete tasks and was unable to lift more than X pounds. X reported symptoms of pain / discomfort that were dominating when X was performing tasks such as lifting, carrying, weighted objects for extended period of time, attempting to reach above head and or lower places. The constant pain to X left shoulders and lumbar region limited X from performing varieties of activities and X had to take frequent breaks to let pain ease in order to continue and or to complete task. Prolonged activities of driving, sitting, walking, walking on uneven surface, carrying, lifting weighted objects, reaching above head / behind, pushing, pulling heavy door, reaching into top cabinets, kneeling or bending forward and pushing up from seated position exacerbated X symptoms of pain / discomfort. X took frequent breaks to let symptoms subside. Hot / cold pack, hot shower, electrical stimulation, massage or topical ointments to affected area, OTC pain medications and therapeutic exercises - physical therapy sessions including X helped to alleviate X symptoms of pain and discomfort. X would benefit from 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: "Per the submitted documentation, the request is not warranted. The request for X for the claimant was determined to be not medically necessary based on the applicable guidelines and the findings in the medical report. The claimant sustained injuries to the left shoulder, including a strain of the long head of biceps and a superior glenoid labrum lesion. While the claimant demonstrated a light physical demand level of

work, the increased pain and discomfort experienced during functional tasks indicated that intensive supervised exercise training may not have been appropriate. Importantly, the claimant was placed at maximum medical improvement (MMI) as of X. According to the Official Disability Guidelines, X. The guidelines also specify that X. Since the claimant had reached MMI, their condition had stabilized, and no further significant medical improvement was anticipated. Thus, the necessity for X was not supported. In summary, the determination concluded that the requested X were not warranted, as they did not align with the established guidelines for medical necessity given that the claimant's current medical status indicated they were at MMI. Therefore, the prospective request for X is non-certified. "Per a reconsideration / utilization review adverse determination letter dated X, by X, MD, the request for X was denied. Rationale: "Per the submitted documentation, the request is not warranted. The request for X for the claimant was determined to be not medically necessary based on the applicable guidelines and the findings in the medical report. The claimant sustained injuries to the left shoulder, including a strain of the long head of biceps and a superior glenoid labrum lesion. While the claimant demonstrated a light physical demand level of work, the increased pain and discomfort experienced during functional tasks indicated that intensive supervised exercise training may not have been appropriate. Importantly, the claimant was placed at maximum medical improvement (MMI) as of X. According to the Official Disability Guidelines, X. The guidelines also specify that X. Since the claimant had reached MMI, their condition had stabilized, and no further significant medical improvement was anticipated. Thus, the necessity for X was not supported. In summary, the determination concluded that the requested X were not warranted, as they did not align with the established guidelines for medical necessity given that the claimant's current medical status indicated they were at MMI. A peer-to-peer discussion was conducted with the provider, during which it was confirmed that the claimant experienced severe pain during the functional capacity evaluation (FCE) and was determined to be functioning at a light physical demand level (PDL). The therapist expressed concerns about the claimant's capacity to handle the demands of a medium PDL, which was required for their job, and suggested that X would be more appropriate. The therapist indicated that the claimant was at risk for reinjury and was uncertain regarding surgical candidacy. Therefore, the request X is non-certified. "Thoroughly reviewed provided records including provider notes and peer reviews. Patient had

completed a considerable amount of X. There was a consideration that perhaps patient would be at MMI if pursued further X. The X had not yet been done because of denial from reviews. Given that X are met based on cited guidelines, along with recommendation that X be pursued prior to reaching supposed MMI, request for X is warranted. Prospective request for X and X is medically necessary and certified.

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

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient had completed a considerable amount of X. There was a consideration that perhaps patient would be at MMI if pursued X. The X had not yet been done because of denial from reviews. Given that X are met based on cited guidelines, along with recommendation that X be pursued prior to reaching supposed MMI, request for X is warranted. Prospective request for X is medically necessary and certified.

Overtaken

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
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

- MILLIMAN CARE GUIDELINES**
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**