Physio
Solutions LLC
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Notice of Independent Review Decision

IRO Reviewer Report

X

IRO Case number: X

Description of the services in dispute:
X

Description of the qualifications for each physician or 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)

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

X, date of birth X, is a X individual diagnosed with primary osteoarthritis of the right shoulder, impingement syndrome, and incomplete rotator cuff tear and

seeking coverage for X. The claimant sustained an injury on X after X fell, causing right shoulder pain. The claimant described a limited range of motion at the right shoulder with weakness. The claimant was referred to X. The claimant did undergo an X. No recent prescription medications for pain were detailed for review. The X right shoulder MRI report noted X. There was X noted. There was X. There was a X suspected. The X evaluation noted moderate anterior tenderness to palpation at the acromion with mild weakness on resisted elbow flexion. There was increased pain with right shoulder abduction with limited abduction to X degrees. There were X noted. There was pain with external rotation.

Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision

The treatment under review being X was denied due to the lack of documentation showing failure of at least X months of non-operative measures.

The current evidence-based guidelines in ODG recommend consideration for X when there is demonstrated failure of reasonable non-operative measures that include X. Pathology and clinical findings should be verified to be consistent with the claimant's symptoms. In this case, the claimant does present with positive exam and imaging findings for X. There are insufficient imaging findings to support the requested X based on the results of the MRI report. The claimant had attended X. The claimant denied any improvement from a X. The records did not detail the use of X.

Failure of reasonable non-operative measures have not been demonstrated to support proceeding with the surgical requests. ODG does recommend post-operative physical therapy as part of a rehabilitation program after surgery to improve pain and functioning. However, as the surgical requests are not indicated, there would be no requirement for the requested X. Therefore, the medical necessity for the X have not been established, and the previous denials are upheld.

Description and source of the screening criteria or other clinical basis used to make the decision

☐ ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase ☐ AHRQ - Agency for Healthcare Research and 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

☒ ODG - Official Disability Guidelines & Treatment 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)