

**P-IRO Inc.**  
**An Independent Review Organization**  
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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 adjusting a X. The diagnoses were unspecified sprain of left shoulder joint, initial encounter (X), unspecified sprain of right shoulder joint, initial encounter (X), unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic (X) and superior glenoid labrum lesion of unspecified shoulder, initial encounter (X). X was seen by X, MD on X for a follow-up one year status post left shoulder arthroscopy, debridement, rotator cuff repair and distal clavicle resection. X completed a total of X. X denied any pain in the left shoulder. A functional capacity evaluation dated X stated X was performing at a medium PDL at the time, which indicated a moderate functional deficit. It was recommended that X. X could use X. A functional capacity evaluation was documented on X by X. X demonstrated maximum effort. The results could be considered valid and reliable. X occupational demand as a X. According to the results of the evaluation, X was performing at a medium PDL at the time, which indicated a moderate functional deficit. The comparison results between X performed on X and X were as follows: the X. A functional capacity evaluation was completed on X by X demonstrating X was performing at a medium PDL, which indicated a moderate functional deficit. Per reports of medical evaluation dated X by X, DC, X had not reached maximum medical improvement but was expected to reach MMI on or about X. Treatment to date included X. Per a letter dated X, the request for X was not certified. Per a peer review report dated X by X-Rice, MD, the request for X was not medically necessary. Rationale: "The claimant is X. The ODG does X. ODG further states that a X. So to indicate that the

claimant has X. According to the ODG, alternatives should be considered. Therefore, the request for X is not medically necessary. "Per a letter dated X by X, DC, "The medical necessity of X. The patient needs to transition back to work as a X. The patient started the X. The very purpose of X. This patient has demonstrated good compliance and progress and is expected to achieve the X. It is, therefore, unreasonable, counterproductive, and contrary to the standard of care to terminate treatment at this juncture. Per Texas Labor Code Section 40\$.021 1 Entitlement to Medical Benefits, employees who sustain a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that (1) cures or relieves the effects naturally resulting from the compensable injury, (2) promotes recovery, or (3) enhances the ability of the employee to return to or retain employment. The above rationale clearly demonstrates that X patient's completion of the work conditioning program will promote recovery, promote Maximum Medical Improvement, and enhance the patient's ability to return to work and promote case resolution." The medical necessity for X. Medical probability indicated that X would successfully complete the X. Authorization for X was requested, which would allow to return X to unrestricted work duty and achieve case resolution. Per a letter dated X, the request for appeal X was upheld. Per a medical review dated X by X, MD, the request for X was noncertified. Rationale: "In this case, the patient underwent surgery on X for X. The patient has X. X functional capacity evaluation on X indicated that X was performing a X. X has been participating in a X. The request for X. The X reportedly improved the patient's left shoulder pain. There is no indication how continued, supervised X. Therefore, based on the records and treatment guidelines, the requested X is not certified. "Thoroughly reviewed provided records including clinical notes and peer reviews. While the patient initially was a candidate for X. The providers are requesting that the patient be allowed an X. However, X is also at this point, and with these injuries, able to

successfully participate in a X. Further deficits can be improved by X. However, based on this citation, the patient has already reasonably been a part of X is not clearly necessary. 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:**

Thoroughly reviewed provided records including clinical notes and peer reviews. While the patient initially was a candidate for X. The providers are requesting that the patient be allowed an X. However, X is also at this point, and with these injuries, able to successfully participate in a X. Further deficits can be improved by X. X cites the Texas Labor code. However, based on this citation, the patient has already reasonably been a part of X not clearly necessary. 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:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- 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
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TMF SCREENING CRITERIA MANUAL