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Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: X; Amendment 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 sustained an injury on X. X injured X right shoulder carrying something heavy overhead. The diagnoses included status post reverse total right shoulder replacement and chronic right shoulder pain. X was seen by X, APRN on X for a follow-up of chronic right shoulder pain due to X. After the injury in X, X was diagnosed with a partial-thickness rotator cuff tear which failed to improve with conservative management. X subsequently underwent X. X was then indicated for X. X did not improve with reverse shoulder arthroplasty. X reported never being out of pain and having limited function and range of motion. X was placed at MMI by X treating surgeon. X was scheduled for surgery the prior year but had to cancel due to health reasons. X continued to have severe pain, getting much worse. The pain was described as sharp, continuous, stabbing (icepick), and gradually worsening. It was rated X. The aggravating factor was movement. X also had very limited function of X shoulder which was deteriorating. X had severe pain daily. X essentially could not use the right arm for activities of daily living. X reported mechanical symptoms including feeling a “sliding or rubbing” feeling in the shoulder join during adduction. X had done X. X had done X. On imaging, X X. Revision X was recommended. The right shoulder examination revealed X. The range of motion of the right shoulder revealed X. Muscle strength in abduction and supraspinatus was X. Per the note, x-rays of the right shoulder showed X. CT scan of the right shoulder dated “X” revealed X. Treatment to date included X. Per the utilization review by X, MD on X, the prospective request for X was non-

certified. Rationale: “Per the submitted documentation, the request is not warranted. The claimant had chronic severe shoulder pain with very limited function despite X. The objective finding showed X. The provider documented that a X. The request may be medically necessary based on the claimant’s clinical presentation; however, the imaging findings showed no evidence of X. Since there was no evidence in the imaging that showed X is not supported. A prior request for X was non-certified as imaging did not show any X. Therefore, the prospective request for X is non-certified. A peer-to-peer call was held with Dr. X at X on X. The provider indicated that the X. Therefore, the prospective request for X is non-certified. “Per the utilization review by X, MD on X, the prospective request for X was non-certified. Rationale: “It appears that the prior non-certification is appropriate. An appeal process was initiated but there was no rationale provided for proceeding with surgery despite the guideline recommendation. Although the claimant has chronic severe shoulder pain with very limited function X. There is a discrepancy between the radiologist’s reading of the X-rays and the provider’s reading. In this regard, the request remains non-certified. Hence, the prospective request for X is non-certified. “In review of the available imaging reports, there were X. There was no evidence of X. There were no other clear indications to proceed with X. Therefore, it is this reviewer’s opinion that medical necessity is not established and the prior denials are upheld. The prospective request for 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:

In review of the available imaging reports, there were X. There was no evidence of a X. There were no other clear indications to X. Therefore, it is this reviewer’s opinion that medical necessity is not established and

the prior denials are upheld. The prospective request for 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