US Decisions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 US
Austin, TX 78731
Phone: (512) 782-4560
Fax: (512) 870-8452
Email: @us-decisions.com

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 Overtuned (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. X was standing up at work and blacked due to a seizure and sustained a left shoulder injury. The diagnosis was other specific joint derangements of left shoulder, not elsewhere classified (X). On X, X was evaluated by X, MD for follow-up of left shoulder complaints. X felt X was getting better. The pain was located in the lateral shoulder, rated at X. The symptoms occurred frequently. X described the pain as dull in nature. The severity of the pain was moderate. The pain radiated to the left arm. Associated symptoms included decreased range of motion. Exacerbating factors included shoulder movement and arm elevation. Relieving factors included X. On examination of the left shoulder, there was tenderness in the anterior shoulder, but not in the lateral shoulder. Palpation revealed no warmth. X was limited in X. X was X. Abduction was X on the left side with pain. Neurologic examination revealed X. X was X. The muscles displayed no weakness. The assessment included X. Treatment plan was to X. X attended a X by X, X on X. X had completed X. X reported X was feeling a lot better. The pain was rated at X. X could perform activities of daily living independently. X could not perform recreational activities independently. X reported being unable to participate fully in one or more community or life events due to impairment associated with current injury. The impairment list consisted of active range of motion, passive range of motion, and pain. X had reached 60% of his functional goal at the visit. X was advised to continue X. An x-ray of the left shoulder dated X revealed no evidence of X. There was X. There was a X. These lesions suggested loose joint bodies. x-rays of the left humerus dated X revealed X. Treatment to date X. Per a utilization review adverse determination letter X / peer review report dated X, the request for X was denied by X, DO. Rationale: “X has completed X. X should be well versed in a home exercise program at this time, and there is no documented contraindication to continuation at home. There are no documented extenuating circumstances that would warrant exceeding guidelines or going outside of them. Therefore, the request for X is not medically necessary." X is not medically necessary and non certified On X, the request for reconsideration of X was placed by X. The medical provider, Dr X, had requested this medical treatment because

there was an ongoing condition(s) that required treatment. The X was medically reasonable and was consistent with the Official Disability Guideline (ODG). The attached medical records supported the efficacy of the X; and established the clinical indication and necessity of this treatment. Therefore, the X should be determined medically necessary for X to reach maximum medical improvement (MMI).Per a reconsideration / utilization review adverse determination letter dated X / peer review report dated X by X, MD, the request for X was denied. Rationale: “In this case, there is no mention of total visits completed or specific response to X. There is also X noted. It is not mentioned why X is not possible. Therefore, X is not medically necessary. “The requested X is not medically necessary. The patient has already completed X. The patient should be well versed on a X. X is not supported by the submitted medical records or the guidelines for the associated diagnosis. No new information has been provided which would overturn the previous denials.

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

Per a utilization review adverse determination letter X / peer review report dated X, the request for X was denied by X, DO. Rationale: “X has completed X. X should be well versed in a X. There are no documented extenuating circumstances that would warrant exceeding guidelines or going outside of them. Therefore, the 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**
- ☒ **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)**