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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 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. The biomechanics of the injury was not available in the records. The diagnosis was sprain of right rotator cuff capsule, initial encounter (X). On X, X, MD evaluated X for chief complaint of status post right shoulder long head of biceps tendon transfer (LHBTT), distal clavicle resection (DCR), and subacromial decompression (SAD) on X. X continued to meet with for postoperative physical therapy (PT) and stated that X had to discontinue physical therapy due to Workers' Compensation denying the recent resubmission due to "excessive visits requested." X was hoping that they could resubmit for only X. The tenderness at the incision was resolved along with pain, but recurrent pain over the long head of biceps tendon sheath. X had near full active / passive range of motion including forward flexion to X degrees, abduction to X degrees, external rotation to X degrees, and internal rotation to X. Motor strength was X in forward flexion, abduction, internal and external rotation. Sensation was intact throughout the upper extremity with resolving peri-incisional numbness. X was still not progressing as well as X would like at the time. X was told that if X would like to proceed with conservative management, Dr. X preferred not to use X. An authorization for the X was provided. Treatment to date included X. Per a peer review report dated X by X, MD, the request for X was denied. Rationale for X: "Based on the provided documentation, the claimant presented with right shoulder pain. The physical examination revealed X. The claimant has been diagnosed with superior glenoid labrum lesion of right shoulder initial encounter; sprain of right shoulder cuff capsule, initial encounter; other articular cartilage disorders, right shoulder; sprain of right acromioclavicular joint, initial encounter; strain of muscle, fascia and tendon of long head of biceps, right arm, initial encounter. Per ODG guidelines. X. A prior denial by Dr. X dated X, was denied on the basis the guidelines do not support the use of this specific treatment for shoulder conditions. The claimant was previously approved for X dated X. A prior denial by Dr. X dated X, was denied on the basis the guidelines do not recommend. The claimant is status X on X. It is noted the claimant has continued pain. However, the guidelines do not recommend this form of treatment for the shoulder.

Furthermore, there was no official diagnostic report provided to corroborate clinical findings to support the request. Therefore, the X is not medically necessary." Rationale for X: "Based on the provided documentation, the claimant presented with right shoulder pain. The physical examination revealed X. The claimant has been diagnosed with superior glenoid labrum lesion of right shoulder initial encounter; sprain of right shoulder cuff capsule, initial encounter; other articular cartilage disorders, right shoulder; sprain of right acromioclavicular joint, initial encounter; strain of muscle, fascia and tendon of long head of biceps, right arm, initial encounter. Per ODG guidelines, X. A prior denial by Dr. X dated on X, was denied on the basis clinical examination does not corroborate anatomic and physiologic correlation for functional gains to be met. It is noted the claimant has attended X. However, X. There is no indication the claimant cannot continue with an at X. Therefore. the request for X is not medically necessary. "Per a peer review report dated X, by X, MD, the appeal request for X was denied. Rationale for X: "In this case, the claimant had pain and decreased range of motion (ROM) and strength. X has been treated with X. However, there is no documentation of functional improvement with X. Therefore, the request for X is not medically necessary." Rationale for X: "In this case, the claimant has pain and decreased ROM and strength. X has been treated with X. However, the X is not indicated. Due to TX law and inability to get agreement with physician this case is non-certified. Therefore, the request for X is not medically necessary." An appeal letter dated X was included in the records requesting X. The requested X is not medically necessary. The submitted medical records do not support the request as the patient had a X. In addition, the guidelines do not support X. Additional X is not indicated as the patient has already exceeded the recommended number of therapy sessions. No new information has been provided which would overturn the previous denials. 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:

The requested X is not medically necessary. The submitted medical records do not support the request as the patient had a X. In addition, the guidelines do not support X. X is not indicated as the patient has already exceeded the recommended number of therapy sessions. No new information has been

provided which would overturn the previous denials. 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)**