True Decisions Inc.
An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #615
Mansfield, TX 76063
Phone: (512) 298-4786
Fax: (888) 507-6912
Email: @truedecisionsiro.com

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

True Decisions Inc.

Notice of Independent Review Decision

Case Number: X Date of Notice: X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured on X. X had a right shoulder injury while at work X. The diagnoses were strain of muscle, fascia and tendon at neck level, and strain of unspecified muscle, fascia and tendon at shoulder and upper arm level, right arm.

On X, X was seen by X, PA/ X, MD, for follow-up evaluation visit. X had a history of work-related injury dated X, where X had an injury to the right shoulder X. Regarding cervical spine, X stated that overall, the symptoms had remained the same. X reported the pain level as X. The range of motion had returned to X. Regarding shoulder pain, X presented for right shoulder complaint. X stated that overall, the symptoms had remained the same. X reported pain level as X. Range of motion was increased. Cervical spine examination revealed X. X was noted on the right side. X was noted. The right shoulder examination revealed X. Range of motion in X dated X were reviewed and X. X was recommended. On X, X was seen by X, PA / X, MD, for follow-up evaluation visit for neck and right shoulder pain. X reported X pain in X right shoulder. X stated that the pain would get worse with activities. Regarding the cervical spine, X stated that overall, the symptoms had remained the same. X rated the pain as X. The right shoulder symptoms had remained the same. X rated the pain as X. Cervical spine examination revealed X. X was noted on the right side. X was noted. The right shoulder examination revealed X. Range of motion in X. X and X was prescribed. X was ordered and X was advised to continue the X. Restricted duty was recommended. Per a Designated Doctor Evaluation dated X completed by X, DC, X presented for examination for work related injury. On X, X suffered from work related injury. At the time, X was not working. At the time, X complained of neck and shoulder pain. X reported numbness,

burning and weakness at right shoulder and right side of neck. X rated ongoing pain X, lowest pain as X and highest pain as X. X indicated the following activities would increase pain: pushing, pulling, reaching overhead, lifting, carrying things from one place to another, weather changes, and any movement. Pain was decreased with X, X, rest / sleep, and hot packs. The right shoulder examination revealed X noted on the X. The range of motion was X, flexion X degrees, extension X degrees, abduction X degrees, adduction X degrees, internal rotation X degrees, and external rotation X degrees. Sensory testing of the X. The strength was intact, X of the neck and right shoulder. Dr. X indicated that X attended X. X stated that both X treating doctor and orthopedist had requested X; however, it was denied by the carrier. It was noted that X still had X on X right shoulder. X only had X. Both X orthopedist Dr. X, DO on X and X treating doctor Dr. X, MD, on X, stated that X could benefit from further X. Dr. X agreed with both and believed that X had not met the maximum medical improvement level, and in all medical likelihood, would benefit from X. Expected MMI date would be on or around X. On X, X was evaluated by X, PT, for X follow-up evaluation visit for neck and right shoulder pain. On X, X was X. X stated that the most aggravating movement was lifting overhead and shoulder shrugging. X also stated that pain extended to the right sternoclavicular joint. Physical examination revealed X. The cervical spine showed range of motion in flexion and extension was X, the side bending on right was X and left was X, the right rotation was X and left rotation was X. The strength in flexion/extension was X. The right shoulder examination showed ROM in flexion was X degrees, extension X degrees, abduction X degrees, internal rotation X degrees and external rotation X degrees. The strength in abduction and external rotation was X. There was X, painful arch sign, and X test noted. X grade X, was present. The activity limitations included lifting at shoulder height and overhead

with up to X pounds, pushing/pulling with up to X pounds, gripping/grasping. It was noted X was unable to participate in regular working duties. X presented to X with symptoms consistent with X. Skilled X was recommended.

Review of x-rays of the cervical spine and right shoulder dated X was X.

Treatment to date included X.

Per a Utilization Review Adverse Determination Letter dated X by X, MD, the request for X was denied. Rationale for denial of X for neck: “ODG recommends X. This patient has a diagnosis of neck strain secondary to the work-related accident on X. Per the provided X records, X has X. The patient has been authorized with X. At the X visit on X, there were some deficits noted in active neck range of motion including active flexion and extension at X of normal side bending X to the right and X to the left and rotation X to the right and within normal limits to the left. The last therapy notes on X did not include a cervical spine exam. At the recent office visit on X, the patient reports unchanged mild X intensity neck pain. The cervical spine exam was largely X. There was X. There was only a X. X have been requested. This request for an X. Additionally, the patient reports only minimal residual pain and now has full cervical spine range of motion with no tenderness and decreased spasm. There are insufficient clinical findings to support the request. There are no objective barriers to X. Thus, the request is not certified.” Rationale for denial of X: “ODG recommends X. This patient has a diagnosis of right shoulder strain secondary to the work-related accident on X. Per the provided physical therapy records, X has X. The patient has been authorized with X. At the X on X, there were mild deficits noted in active right shoulder range of motion including normal

flexion and external rotation und near full abduction of X degrees and near full internal rotation of X degrees. The last therapy notes on X did not include a right shoulder exam. At the recent office, visit on X, the patient reports unchanged mild X intensity right shoulder pain. The right shoulder exam was X. X have been requested. This request for an X. Additionally, the patient reports only minimal residual pain and after X authorized X. There are insufficient clinical findings to support the request. There are no objective barriers to a X. Thus, the request is not certified."

Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale for denial of X: "According to ODG by MCG, "Allow for fading of treatment frequency (X. Sprains and strains of neck X visits over X weeks." In this case, the patient has completed at X. The guidelines do not support X. Therefore, the request is not certified." Rationale for denial of X for right shoulder: "According to ODG by MCG. "Allow for fading of treatment frequency (X. Sprained shoulder; rotator cuff tear: Medical treatment sprain: X visits over X weeks." In this case, the patient has completed at least X. The guidelines do not support ongoing X. Therefore, the request is not certified."

Thoroughly reviewed provided records including provider notes and peer reviews.

While there are therapy guidelines such as with ODG that specify a number of visits for specific shoulder pathology, such as X. Guidelines are guidelines and not rigid rules. This patient did get therapy beyond the cited guidelines to X visits. It is documented that the patient has X. While it is possible that the patient could potentially perform a X. X is medically necessary and certified.

True Decisions Inc.

Notice of Independent Review Decision

Case Number: X Date of Notice: X

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

Thoroughly reviewed provided records including provider notes and peer reviews.

While there are therapy guidelines such as with ODG that specify a number of visits for specific shoulder pathology, such as X. Guidelines are guidelines and not rigid rules. This patient did get therapy beyond the cited guidelines to X visits. It is documented that the patient X. While it is possible that the patient could potentially perform a X. X is medically necessary and certified.

Overturned

True Decisions Inc.

Notice of Independent Review Decision

Case Number: X Date of Notice: X

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

True Decisions Inc.

Notice of Independent Review Decision

Case Number: X

Date of Notice: X