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Notice of Independent Review Decision

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)

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 is a X who was injured on X after X. The diagnoses were status post right shoulder diagnostic arthroscopy, open rotator cuff repair, and right shoulder pain, weakness, and stiffness. On X, X was seen by X, MD, for follow-up for X ongoing complaints. X was status post right shoulder diagnostic arthroscopy, open rotator cuff repair on X. X was progressing slowly but steadily with X. Dr. X opined it was medically necessary to continue X for continued range of motion and strengthening of the right shoulder in order to help ensure X that X could regain X normal function and return to work without restrictions. On examination, X was alert and cooperative. The wound was clean and dry with no evidence of infection. The range of motion and pain were improving slowly. The treatment plan included X. On X, X was evaluated by X, PT, for X re-evaluation visit. This was the X care visit. It was noted that X had made good progress since the initial evaluation. X demonstrated an improvement in passive range of motion (flexion X degrees, abduction X degrees, internal rotation X degrees and external rotation X degrees); active range of motion (flexion X degrees, abduction X degrees, internal rotation X and external rotation at base of skull), grip strength and shoulder strength. X active flexion, abduction and external rotation had decreased since the last re-evaluation. X reported that decrease in AROM was due to severe spasms X was having in X chest and trunk. At the time, X presented with right upper extremity weakness, decreased right shoulder function and ROM, decreased scapular stability and posture deficits. X reported difficulty in overhead activity, heavy household chores, work-related tasks, and recreational exercise. X would be benefited from X. The treatment plan included X. On X, X presented to Dr. X for standing right shoulder pain and stiffness. X had been progressing slowly but steadily with physical therapy. However, further therapy had been denied through X Workers' Compensation Insurance. At that time, X had regressed significantly as far as X pain level and range of motion as well as strength. At the time, X stated that X pain was fairly continuously X. X had lost significant range of motion and strength. Dr. X opined that it was medically necessary to X. On examination, X was alert and cooperative. The wound was clean and dry with no evidence of infection. At the time, X had less than X degrees of forward flexion and abduction and had less than X degrees

of internal and external rotation of the right shoulder with significant pain. The strength was X in right shoulder strength testing. The pain was worse. The assessment was right shoulder diagnostic arthroscopy, open repair on X, and worsening right shoulder pain, stiffness, and weakness. Dr. X noted that due to significant regression of function in the right shoulder, he felt it was imperative that X be granted X. On X X was seen by Dr. X for follow-up for X ongoing complaints. X had been progressing slowly but steadily with physical therapy. However, further therapy had been denied through X Worker's Compensation Insurance. X had provided a list of daily activities that X had difficulty with or could not do, which included lifting anything more than 5-10 pounds such as boxes or blenders; reaching overhead was very difficult and painful. X could not garden. X could not walk X dogs because it was too painful, and X lacked the strength to control them. X was still having a great deal of difficulty in sleeping and could not sleep on X right side and had difficulty even sleeping on the left side. Vacuuming was extremely difficult. X had difficulty in pushing trash cans to the curb and could not pull them because of pain. X had difficulty in getting out of a bathtub, pool, or hot tub. X continued to report significant tremors and mid range of motion when trying to eat or drink. X continued to complain of significant muscle spasms about the right shoulder and right arm, which were worsening. X could not use a blow dryer or do X hair for more than 30 seconds at a time due to pain and weakness. On examination, the wound was clean and dry with no evidence of infection. At the time, X had less than X degrees of forward flexion and abduction and had less than X degrees of internal and external rotation of the right shoulder with significant pain. The strength was X in right shoulder strength testing. The pain was worsened. Dr. X noted they would resubmit the request for X. Treatment to date included X. Per a utilization review adverse determination letter dated X and a Peer Review Report dated X by X, DO, the request for X was denied. Rationale: "It was noted that the claimant will benefit from X. However, there was no office visit note available for review by the requesting physician provider, Dr. X, detailing the claimant's current subjective findings, current objective physical exam findings, current post-op condition, current work status, and current treatment plan. Also, the X post-op PT visits completed already well exceeds the guidelines criteria maximum of X to X PT visits for the type of surgery done and the X being requested would be further in excess of the guidelines and there was no mention why the claimant could not transition into a home exercise program. Therefore, the request is not medically

necessary. "Per a utilization review adverse determination letter dated X and a Peer Review Report dated X by X, MD, the appeal request for X was denied. Rationale: "The request is not medically necessary. Per ODG, "Rotator cuff syndrome/Impingement syndrome: Medical treatment: X visits over X weeks Post-injection treatment: X visits over X week Post-surgical treatment, arthroscopic: X visits over X weeks Post-surgical treatment, open: X visits over X weeks" In this case, claimant has flexion at X degree, abduction at X degrees, IR at the X. X has had X therapy sessions and abduction is only at X degrees and X. Therefore, the request for Appeal X is not medically necessary." Per a note dated X, Dr. X wrote that X had been denied several times. There were delays of several weeks between X and denials. This was an on-the-job injury sustained on X. Dr. X did not treat X until X. X ultimately underwent X. Initially, X progressed well with X. X had regressed significantly with X function and increased pain. It was medically necessary and imperative that X got more X. Based on the submitted medical documentation, the requested X is not medically necessary. The records reflect that the patient has had X. The number of sessions completed already exceeds the recommended guidelines. The additional records provided from the treating provider do not support the request. The patient should be well versed on a home exercise program for ongoing deficiencies. 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:

Based on the submitted medical documentation, the requested X is not medically necessary. The records reflect that the patient has had X. The number of sessions completed already exceeds the recommended guidelines. The additional records provided from the treating provider do not support the request. The patient should be well versed on a home exercise program for ongoing deficiencies. 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)**