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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 suffered a work-related injury to X. The diagnoses included fracture of proximal end of right humerus status post hemiarthroplasty on X.

X was seen by X PA-C on X for postoperative follow-up. X had X. X had been complaining about non weight bearing status; attending occupational therapy without concern. X denied numbness, tingling, or other signs of paresthesias. On examination, the incision site was clean, dry, and intact. X was X. Right shoulder flexion was limited to an estimated X degrees; abduction limited to X degrees; and extension limited to X degrees. X was able to internally rotate both agree; was unable to reach lumbar spine. X-rays of the right shoulder demonstrated X.

On X, X was seen by X, MD for right shoulder follow-up. After the injury, X underwent X. X had been seen at intervals in the clinic and had been deemed ready for occupational therapy; however, that was denied. X had good pain control but wished that X had more range of motion in X shoulder. X denied numbness, tingling, or paresthesias. Right shoulder examination revealed elevation to X degrees with a soft endpoint that could be forced to about X degrees, abduction to about X degrees which

can be forced to about X degrees with some difficulty, external rotation to about 45 degrees, and internal rotation of right thigh. X-rays of the right shoulder had X.

Physical therapy progress note dated X by X, PT documented that X was approximately X better. X had received X plus initial evaluation on X. X pain decreased. Right shoulder range of motion showed passive flexion X degrees (prior X degrees), passive abduction X degrees (prior X degrees), passive external rotation X degrees (X degrees), active flexion X degrees (prior X degrees), and active abduction X degrees (X degrees). X strength in external rotation was X pounds, internal rotation was X pounds, and abduction was X pounds. X was independent in a home exercise program. X tolerated the treatment well. X visits were recommended.

Treatment to date included X.

Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “Based on response in X. Therefore, the request is not medically necessary.”

Per the utilization review by X, MD on X, the request for appeal X was non-certified. Rationale: “Previous Utilization Review on X was non-certified, stating that based on the response to X. The requested X is not medically necessary. The submitted medical records do not clearly demonstrate the number of sessions which have been completed. Further clarification is necessary. As such, the guidelines have not been met. Therefore, the request for appeal X is upheld and non-certified.”

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per the utilization review by X, MD on X was non-certified. Rationale: “Based on response in X. Therefore, the request is not medically necessary.” Per the utilization review by X, MD on X, the request for appeal X was non-certified. Rationale: “Previous Utilization Review on X was non-certified, stating that based on the response to X. The requested X is not medically necessary. The submitted medical records do not clearly demonstrate the number of X. Further clarification is necessary. As such, the guidelines have not been met. Therefore, the request for appeal X is upheld and non-certified.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient X on X. The total number of X. It is unclear if the current request would exceed guidelines. It appears that there were X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. Is The Request For Appeal 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 clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “Based on response in X. Therefore, the request is not medically necessary.” Per the utilization review by X, MD on X, the request for appeal X was non-certified. Rationale: “Previous Utilization Review on X was non-certified, stating that based on the response to X.

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The requested X is not medically necessary. The submitted medical records do not clearly demonstrate the number of X. Further clarification is necessary. As such, the guidelines have not been met. Therefore, the request for appeal X is upheld and non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient underwent X on X. The total number of X. It is unclear if the current request would exceed guidelines. It appears that there were X that were either not completed, or no documentation was provided to establish efficacy of treatment. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. Is The Request For Appeal X is not medically necessary and non-certified

Upheld

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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

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