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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 fell off a X. The diagnoses included partial tear of left rotator cuff; adhesive capsulitis of right shoulder; closed displaced comminuted supracondylar fracture of right humerus without intercondylar fracture.

X was seen by X, MD on X for right upper extremity pain. X was status post X on X. X spracondylar humerus fracture went on to heal without any complications, but X continued to complain of right shoulder pain, weakness, and stiffness. X symptoms and examination were consistent with right shoulder rotator cuff injury. Examination of the right upper extremity revealed X. X exhibited pain throughout range of motion. X experienced profound weakness with X.

An MRI of the right shoulder on X showed X.

Treatment to date included X.

Per an utilization review by X, MD on X, the request for X was non-certified. Rationale: “In this case, the claimant complains of right shoulder pain despite conservative measures. An MRI of the right shoulder revealed X. Examination of the right upper extremity revealed X. However, due to Texas jurisdiction, modification cannot be made in the absence of a successful peer to peer call with agreement from the treating provider. As such, the request is not certified.”

X was non-certified. Rationale: “Per ODG, "1. X. 2. X. 3. X.' In this case,

there is no documentation to indicate that the claimant has X. As such, the request is not certified."

Per the utilization review by X, DO on X, the request for X was upheld and non-certified. Rationale: "The previous Utilization Review on X was non-certified, stating examination of the right upper extremity revealed a X. However, due to Texas jurisdiction, modification cannot be made in the absence of a successful peer-to-peer call with agreement from the treating provider. Per the available medical record, there is documentation of functional limitations related to the right shoulder on clinical exam consistent with an X. There is no documentation of any X. The request is not medically necessary and exceeds the guidelines. Therefore, the request for X is upheld and non-certified."

The request for X was upheld ad non-certified. Rationale: "Previous Utilization Review on X was non-certified, stating in this case, there is no documentation to indicate that the claimant has X. Per the available medical record, there is documentation of functional limitations related to the right shoulder on clinical exam consistent with an X. There is no documentation of any X. The request is not medically necessary and exceeds the guidelines. Therefore, the request for X is upheld and non-certified."

Based on the submitted medical records, the claimant has not demonstrated X. The medical records submitted do not clearly demonstrate sufficient X. Exhaustion of conservative treatment has not been established. As such, 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 records, the claimant has not demonstrated X. The medical records submitted do not clearly demonstrate sufficient X. Exhaustion of conservative treatment has not been established. As such, 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:

☐ 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