MedHealth Review, Inc.
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Notice of Independent Review Decision

SENT TO: Texas Department of Insurance
Managed Care Quality Assurance Office
(MCQA) MC 103-5A Via E-mail
IRODecisions@tdi.texas.gov

X

RE: IRO Case #: X
Name: X
X**DATE NOTICE SENT TO ALL PARTIES:** 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:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a X who sustained an industrial injury on X and is seeking authorization for X. Previous treatment has included X. Previous surgeries included primary X.

Operative Report dated X was for a primary right shoulder rotator cuff repair. Progress report dated X has the injured worker presenting X days status X. X is taking X with improvement. X has severe pain, tingling, and X. The exam reveals the X. The right shoulder motion is X. Strength is X. There is X. There is guarding on the right side. X-rays of the right shoulder reveal X. The treatment plan included X. Follow-up evaluation dated X has the injured worker stating that overall, the right shoulder symptoms have X. The pain level is X. Range of motion is X.

Numbness and tingling X. Upper extremity weakness remained the same. The right shoulder exam reveals X. The range of motion is X. Muscle testing is X. X is wearing a sling and the range of motion was not tested today. The treatment plan included X. Physical therapy evaluation dated X has the injured worker seen for right shoulder X). X has had X. X pain is rated X. The right shoulder range of motion is (active/passive) elevation X, external rotation to the side X, and CBA X. Strength is not testing. X Q-DASH score is X. The treatment plan included X.

Progress report dated X has the injured worker presenting about X weeks (X). Therapy has been scheduled with improvement in the right shoulder range of motion. X has severe post-op pain in the right shoulder. There is random, moderate tingling on the distal side of the right shoulder along with moderate tingling on the distal side of the right shoulder along with moderate swelling on the right arm. X is taking X. The exam of the shoulder reveals the scar is well-healed. The passive range of motion is elevation X and external rotation is X. Strength is X. There is diffuse tenderness on the right side. The treatment plan included a X. X trialed an X which has improved the right shoulder pain. X will benefit from an X. Physical therapy treatment note dated X has the injured worker with pain rated at X. X was in a lot of pain after the last therapy visit and had to ask for more pain medication from the doctor. Therapy was provided (X).

Follow-up Report dated X has the injured worker with decreased overall right shoulder symptoms. The pain is rated X. X range of motion has increased and the numbness and tingling has resolved. Upper extremity weakness remained the same. The right shoulder exam reveals X. Range of motion is X. Muscle testing is improving. The treatment plan included X. Physical therapy treatment encounter note dated X has an improved pain level from X to X. Therapy was provided (X). Physical therapy treatment encounter note dated X has an increased pain level from X to X. X is still in a lot of pain but wants to get better. The rainy weather may be the reason for X pain increase. X has pain, impaired function, weakness, stiffness, numbness/tingling. Therapy was provided (X). Progress report dated X has the injured worker with about X months post-operative with completion of therapy with improvement. X has random, moderate to severe pain, tingling, and swelling in the right shoulder. The exam reveals the right shoulder range of motion active elevation X, passive elevation X, and passive external rotation X. Strength is X in the supraspinatus and infraspinatus and X in the subscapularis. There is diffuse tenderness to palpation on the right. The treatment plan included X.

Follow-up Report dated X has the injured worker with decreased right shoulder symptoms. Pain is rated X. The range of motion has increased. Numbness and tingling have resolved. The upper extremity weakness

has remained the same. The right shoulder exam X. Abduction and flexion remained the same at X degrees. Muscle testing is X. The treatment plan included X. Therapy re-evaluation/progress report dated X has X pain level as X. The range of motion is (active/passive) elevation X, external rotation to side X, and CBA X. X active range of motion is improved by X from X to X. X pain has improved from X to X. The Q-DASH score improved from X to X. The treatment plan included X. Progress report dated X has the injured worker X months and X week post-operative, attending X. X has constant severe pain, tingling, tightness, and moderate swelling in X right shoulder. The exam reveals the X, passive elevation X, passive external rotation X, passive external rotation in abduction is X, and passive internal rotation in abduction is X. Strength is X in the supraspinatus, infraspinatus, and subscapularis. There is diffuse tenderness to palpation on the right. The treatment plan included X.

Utilization Review dated X is a non-certification for X. The rationale states, the claimant has pain and X. However, X has had X sessions approved. Quantity exceeds guidelines. Therefore, the request for X is not medically necessary.

Letter of Medical Necessity dated X has the injured worker X. The treatment protocol for this case takes the first X weeks X. For the following X, the patient is able to initiate active/active assisted range of motion

for external rotation, elevation, and cross-body abduction. Then at X weeks, the patient focuses on X. The final X weeks post-operatively the patient will continue with X. This patient is X months and X weeks post-operative and has only had X weeks of X. X range of motion has been improving with range of motion as elevation X active and X passive (improved by X degrees), external rotation to side is X active and X passive (improved by X degrees), and “CBA” X active and X passive (improved by X degrees). X functional ability has improved with an improved Quick Dash score from X to X, which is noted to be a significant difference. Follow-up report dated X has the injured worker with right shoulder symptoms which have remained the same with pain rated X. The range of motion has remained the same and the upper extremity weakness has remained the same. The exam revealed the right shoulder diffuse tenderness has decreased. The range of motion is abduction to X degrees and flexion decreased to X degrees. Muscle testing is improving. The treatment plan states X sees Dr. X for the shoulder and he released X to light duty starting X. Utilization review dated X non-certified the appeal of X. The rationale states X has had X prior X. Physical examination revealed right shoulder range of motion with elevation X degrees active and X degrees passive, external rotation X degrees passive, external rotation in abduction X degrees passive, and internal rotation in abduction X degrees passive. Strength is X in supraspinatus, infraspinatus, and subscapularis.

There is diffuse tenderness on the right shoulder. There is no documentation of sustained objective functional improvement with the X. There is no indication of deficits expected to improve with X. There is no indication the patient is unable to utilize a X. Moreover, an additional X exceed the guideline recommendations and there are no extenuating circumstances to deviate from the guidelines or go outside of them.

Progress report dated X has the injured worker almost X months post-operative. Therapy was denied twice due to there is no indication the patient is unable to utilize a X. X is taking medications and working restricted duty. X has constant, severe pain in the right shoulder along with tingling and swelling. The exam reveals the right shoulder range of motion active elevation X, passive elevation X, passive external rotation X, passive external rotation in abduction is X, and passive internal rotation in abduction is X. Strength is X in the supraspinatus and X in the infraspinatus and subscapularis. The treatment plan included X.

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

As per ODG, “X”

This X sustained an industrial injury on X and is seeking authorization for X. X underwent primary right shoulder arthroscopic rotator cuff repair on X. X has been attending X.

X presented on X almost X months post-operative. Therapy was denied twice due to there being no indication that the patient is unable to utilize a X. X is taking medications and working restricted duty. X has constant, severe pain in the right shoulder along with tingling and swelling. The exam reveals the right shoulder range of motion active elevation X, passive elevation X, passive external rotation X, passive external rotation in abduction is X, and passive internal rotation in abduction is X. Strength is X in the supraspinatus and X in the infraspinatus and subscapularis.

The therapy re-evaluation demonstrated improvement in X range of motion and strength. X active range of motion is improved by X from X to X. X pain has improved from X to X. The Q-DASH score improved from X to X. There are continued limitations noted in X strength and motion; however, there is limited documentation of clinical issues that do not appear to be able to be addressed by an independent, active, self-directed home therapy routine. X has attended over the ODG recommended/guideline supported post-operative physical therapy sessions. Rationale for other than a prescribed and self-administered X is

not demonstrated or supported at this time. Therefore, the requested X is not medically necessary.

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

☐ 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY 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)**