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***Notice of Independent Review Decision  
Amendment X***

**IRO REVIEWER REPORT**

**Date:** X Amendmet 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 was injured on X. X was using a X. X reported hitting the left fifth digit and twisting X arm and right shoulder. The diagnosis was tendinopathy of right rotator cuff.

On X, X was seen by X, PA for review of right shoulder MRI results. X had done X. X still had some mild pain with chores around the house such as holding an object for a prolonged period or picking heavy objects up. X was not taking pain medications. X had not returned to work yet. X worked as a X and performed X. The right upper extremity showed X was noted. There was full range of motion. X had full strength X throughout all ranges of motion of the shoulder. No instability was noted with stress testing of the shoulder. All provocation tests were X. X was improving with X. X was recommended to continue with no operative treatment. X was not ready to return to work. X stated X was unable to do restrictions for X position. X was recommended to X.

X had a physical therapy evaluation and treatment by X, PT on X for pain in right shoulder and effusion of right shoulder. Examination showed the right shoulder active range of motion was unremarkable. X had weakness and pain in right shoulder. X present physical demand level was medium-heavy. Work conditioning initial X hours and additional X hour was recommended. X was recommended to X.

An MRI of the right upper extremity dated X was X. X was noted. X was noted. There was X. An MRI of the right shoulder dated X revealed X. Anterior fibers of the supraspinatus were attenuated with bursal and articular intermediate-grade partial-thickness tears at the myotendinous junction. X was noted. Mild encroachment upon the X was noted secondary

to 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: "ODG lists specific criteria that must be met for a person to be indicated for work conditioning (WC). Per ODG, "the best determinant to get a patient back to work is with a X." In the clinic note dated X by X, P.A., neither the documentation nor the medical rationale for the X. The only mention of a X notes, and even in this document, the template signature box was void of a signature by a physician or midlevel provider. Per ODG, "the best determinant to get a patient back to work is with a X. " Further, unless the employer prohibits the return to work in a modified capacity, the patient should attempt to return to work in a modified capacity as recommended by ODG before resorting to a X. It should then be attempted to build up to full work capacity. The provider noted that the patient had been responding well to X. It appears that it is not the medical provider who wants and orders the WC, but rather, a request from X. Determining the need for WC should come from a physician or a mid-level provider, not initiated by physical therapy. ODG also "recommends X." Due to these missing elements that support utilizing a WC program, the request is not medically necessary. Therefore, the request for X, is non-certified."

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Clinical Rationale: Per ODG, "Timelines: X. " In this case, there is no documentation of significant complicated issues, no description of the patient's current work demands, and no indication of failed modified duty. Additionally, the examination findings reflect normal range of motion and strength. Therefore, the request is not certified."

Thoroughly reviewed provided records including provider notes and peer reviews.

Treating therapist has recommended a reasonable X. The patient has made significant progress in X. Given request meets the guidelines cited by peer reviews, requested X is warranted. X is medically necessary and certified

**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.

Treating therapist has recommended a X. The patient has made significant progress in X. Given request meets the guidelines cited by peer reviews, requested X is warranted. X is medically necessary and certified

Overtured

**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