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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 was injured in "X." X reported a X. The diagnoses included chronic pain syndrome, myalgia of other site, pain in left shoulder, impingement syndrome of left shoulder, long term (current) use of opiate analgesic, unspecified fracture of upper end of left humerus, subsequent for fracture with malunion, other long term (current) drug therapy and encounter for therapeutic drug level monitoring.

On X, X was seen by X, MD for left shoulder pain. X reported left shoulder pain continued at a constant X with an increase to X with activity. X was told by orthopedics X would likely need to undergo a X. X stated X would like to avoid surgery, if possible. X completed requested X. X continued to actively engage (since the X) in other non-operative conservative treatments to include X. X reported that X did these X. Pain was described as aching. That day, the left shoulder pain was rated as X and was severe in nature. X reported the pain occurred constantly. X reported that the pain intensity was the same since previous visit. Pain was alleviated by sitting, medication, rest, and injection therapy. Pain was aggravated by activity, walking, and standing. Examination showed X. Shoulder examination showed X. Moderate pain was

noted with X. Moderate-severe pain was noted with X. The assessment included X. X had chronic left shoulder pain which had been persistent despite multiple treatments to include X. Therefore, implantation of X was recommended. This procedure would be done with X. This procedure would be done with X, next available.

On X, X was seen via telemedicine by Dr. X for left shoulder pain. That day X was following up on medication changes made at previous visit and continued care of left shoulder pain. X reported shoulder pain was X. X reported X had not received the X. X reported X had not heard anything on X end regarding the authorization for the X

X. X continued to actively engage (since the X) in other non-operative conservative treatments to include X. X reported that X did these X. Pain was described as aching. Pain was rated as X and was severe in nature. X reported the pain occurred intermittently. X stated that the pain intensity was the same since prior visit. Pain was alleviated by rest and aggravated by activity. Examination showed X. Shoulder examination showed X. Moderate pain was noted with X. Moderate-severe pain was noted with X. The assessment included X. X was prescribed. X was recommended.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by

X, MD the request for X was denied. Rationale: "Regarding the request for X, the ODG does not recommend the use of X stating, "X and X are considered experimental, investigational or unproven by some commercial carriers. X involves X. There is insufficient evidence to support the safety and effectiveness of X." There are no exceptional factors noted to support the use of this treatment modality outside the guideline recommendations."

Per a utilization review adverse determination letter dated X by X, MD the reconsideration request for X was denied. Rationale: "Based on the clinical information provided, the Reconsideration for X is non-certified. The initial request was non-certified noting that, "Regarding the request for X, the ODG does not recommend the use of X stating, "X and X are considered experimental, investigational or unproven by some commercial carriers. X involves X. There is insufficient evidence to support the safety and effectiveness of X." There are no exceptional factors noted to support the use of this treatment modality outside the guideline recommendations." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The Official Disability Guidelines note that X is not recommended. It is noted that there are still gaps in knowledge requiring further research. There do not appear to be exceptional factors to support the request outside guideline recommendations. Therefore, medical necessity is not established in accordance with current evidence based guidelines."

Thoroughly reviewed provided records including provider notes and peer reviews.

While some insurers and ODG criteria may consider X, there are some Indications for patients that have exhausted other less invasive or more accepted treatment options. However, patient's problem appears to be related to shoulder arthritis and has been recommended for shoulder replacement. There does not appear to be an identified X and there does not appear to have been investigation with electrodiagnostic workup. Thus, request for X is not indicated. 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:**

Thoroughly reviewed provided records including provider notes and peer reviews.

While some insurers and ODG criteria may consider X. However, patient's problem appears to be related to shoulder arthritis and has been recommended for X. There does not appear to be an X. Thus, request for X 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