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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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 Overtuned (Agree in part/Disagree in part)

☐ Upheld (Agree)

Provide a description of the review outcome that clearly states

whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. While working on a X, X. When X realized the X. The diagnosis was other injury of muscle, fascia, and tendon of other parts of biceps, left arm, subsequent encounter (X); other specific joint derangements of left shoulder, not elsewhere classified (X); and pain in left shoulder (X).On X, X was seen in follow-up by X, MD. X stated the pain level was X. X continued X was denied despite X showing continued progress with X. X continued to have some limitations with end-range range of motion and strength / endurance. X presented to the clinic for a left shoulder and left upper arm complaint and stated that overall, the symptoms had decreased. X reported a pain level of X and stated range of motion had remained the same. Numbness and tingling remained the same. Upper extremity weakness remained the same. Swelling decreased. Left shoulder examination noted unchanged diffuse tenderness anteriorly and posteriorly. Range of motion showed abduction, flexion, and internal and external rotation remained the same. Muscle testing revealed weak supraspinatus, infraspinatus, teres minor, and subscapularis (SITS) muscles. Left upper arm revealed diffuse tenderness anteriorly, posteriorly, and in the bicipital groove, remained the same. Range of motion revealed abduction, flexion, extension, and internal and external rotation remained the same. Muscle testing revealed stable decreased strength. It was noted that X underwent surgery and had been progressing through the postoperative physical therapy protocol. The assessment was other injury of muscle, fascia, and tendon of other parts of biceps, left arm, subsequent encounter (X); other specific joint derangements of left shoulder, not elsewhere classified (X); and pain in left shoulder (X). X was advised to take X as needed. Since X was denied

despite X steady progression, Dr. X would order an X. Restricted duty work status was continued. Restrictions included X. Restrictions also included no lift / carry / push / pull over X pounds and no climbing ladders. Per the X office visit note, review of left shoulder x-rays from X, was negative for fracture of dislocation. An incidental finding was X. Also, review of left upper arm – humerus x-rays from X, was negative for fracture or dislocation. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Regarding the request for X, the Official Disability Guidelines do not recommend it for screening or routine monitoring of rehabilitation programs including physical therapy or work conditioning, for prediction of future reinjury, for establishing maximum medical improvement (MMI), or permanent work restrictions, or for rating permanent impairment. The evaluation is recommended when a worker actively participates in the decision to return to a specific job, a job demand analysis or job description is available, and case management is hampered by complex issues (e.g., prior return-to-work attempts have been unsuccessful, conflicting medical reports on worker's capacity to perform a modified job, complex injuries of multiple body parts require detailed exploration of worker's overall occupational capacities). In this case, on X, the claimant X. The X office visit documented X left shoulder/upper arm pain, decreased symptoms/swelling, and unchanged range of motion/numbness-tingling/and weakness. The left shoulder/upper arm exam revealed X. The diagnoses included left biceps injuries of muscle, fascia, and tendon, left shoulder derangement, and pain. The treatment plan was a referral to the X. The claimant's work status was restricted duty. Based on the review of records, the guidelines X

. Further, the recent office visit documented a work status of restricted duty. However, it is unclear from the records if the claimant was currently working, and if so, what was the job description, and whether a return to work had been attempted. There is no explicit documentation of the claimant wanting to return to work. For these reasons and non-recommendation by the guidelines, the request for X is non-certified. Primary Reason(s) for Determination: Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced below, this request is non-certified. Based on the review of records, the guidelines X. Further, the recent office visit documented a work status of restricted duty. However, it is unclear from the records if the claimant was currently working, and if so, what was the job description, and whether a return to work had been attempted. There is no explicit documentation of the claimant wanting to return to work. For these reasons and non-recommendation by the guidelines, the request for X is non-certified. “Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “Per evidence based guidelines, X are not recommended for X. X may be indicated when worker actively participates in decision to return to specific job, a job demand analysis or job description is available to examiner, the worker has new injury with confirmed objective deficit on physical examination and unknown work capacity or when the worker is X. X is tailored to worker's specific job task or essential job duty, and is specific to region of injury. Case management may be complicated by complex issues, such as prior unsuccessful return-to-work attempts,

conflicting medical reports on the worker's capacity to perform a modified job, or injuries involving multiple body parts requiring a detailed exploration of the worker's overall occupational capacities. Timing for an X is appropriate when the worker is close to or at MMI, and all key medical reports have been provided to those administering and interpreting the X, with additional or secondary conditions clarified. In this case, the claimant sustained a work-related injury on X. X underwent X on X. X was previously treated with X. However, the objective efficacy of these treatments is unknown. Moreover, the available records did not mention the specific physical demands of X employment. There is no employer contact noted and no clear job duty to address for return to work. There was a prior adverse determination on X for the same request as the recent office visit documented a work status of restricted duty. However, it was unclear from the records if the claimant is currently working, and if so, what were the job description, and whether a return to work had been attempted. There was no explicit documentation of the claimant wanting to return to work. It still remained relevant that there are no exceptional factors or additional records were provided to overturn the previous non-certification/determination. Guidelines do not support medical necessity for this request. Therefore, the request for X is non-certified. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is not certified. There is no clear rationale for the requested test. Thoroughly reviewed provided records including provider notes and peer reviews. The patient had X. They have exhausted the X but are not yet at the level where they are ready to return to work other than restricted duty. The provider documentation meets the guidelines cited for requirements for X. Further details/requisites will be met during X. Prospective request for 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. The patient had X. They have exhausted the X but are not yet at the level where they are ready to return to work other than restricted duty. The provider documentation meets the guidelines cited for requirements for X. Further details/requisites will be met during X. Prospective request for X is medically necessary and certified. Overturned

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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **PRESLEY 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)**