

Applied Resolutions LLC

An Independent Review Organization

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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:

- | | |
|--|--------------------------------|
| <input checked="" type="checkbox"/> Overturned | Disagree |
| <input type="checkbox"/> Partially Overturned | Agree in part/Disagree in part |
| <input type="checkbox"/> Upheld | Agree |

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X was X. X tried to pull the X. The diagnoses were sprain of right shoulder girdle, pain in right shoulder and strain of muscle, fascia and tendon at right shoulder and upper arm level.

Per a Request Information dated X by X, PA-C, postoperative X was requested. Designated Doctor Examination (DDE) performed on X stated X was X.

X was seen by X, PA-C / X, MD on X for complaints of pain in the right shoulder, which was rated X. X was status post right reverse total shoulder replacement. X complained of lot of stiffness. X stated overall the symptoms had increased. The range of motion remained the same. The pain had increased possibly due to cold weather. Upper extremity weakness remained the same. Examination of the right shoulder showed diffuse tenderness remained the same. The abduction remained the same at X degrees. Flexion increased to X degrees. External rotation remained the same at X degrees. Muscle strength was decreased in the right shoulder. X continued to have limited range of motion to just about the shoulder height and decreased strength. Review of x-ray of right shoulder dated X showed X. X was noted. Review of an MRI of the right shoulder dated X showed X. The DDE report done on X by X, DC indicated, X did not have the full amount of Official Disability Guidelines recommended X. X would then need a X. The estimated date of maximum medical improvement was X. Per a functional capacity evaluation dated X, X was at a light duty level of function. X was re-ordered due to not having the full complement of Official Disability Guidelines authorized X. X was placed on restricted duty.

X visited X, PA-C / X, DO on X for complaints of right shoulder pain rated X and lot of stiffness. Overall, X symptoms had increased. The range of motion remained the same. X felt the pain had increased due to cold weather. Upper extremity weakness remained the same. Examination of the right shoulder showed diffuse tenderness remained the same. Range of motion remained the same with abduction X degrees and external rotation X degrees. Flexion was decreased to X degrees, Muscle testing was decreased. X continued to have limited range of motion to just about shoulder height and decreased strength.

A Designated Doctor Examination was completed on X by X, DC. It was opined that X had not reached a level of maximum medical improvement at the time and therefore did not qualify for an impairment rating evaluation. X had not been afforded reasonable, adequate opportunity of care for X compensable conditions based on the ODG recommended allowances, which were X. In this case, the ODG guidelines were not applicable as there was a delay in initiating appropriate care. X had a X. X treating doctor had recommended a X. At the time, X was to be allowed to complete a X. X did have a job to return to and there was an expectation of further material recovery from X injury and subsequent X. The estimated date of maximum medical improvement was on or around X.

A X re-evaluation was documented on X by X, PT, DPT. X reported increased soreness of right shoulder but denied any pain. X was taking pain medications. Examination of the right shoulder showed active flexion X degrees with end range pain, active extension X degrees, active abduction X degrees with end range pain, active internal rotation to coccyx, and active external rotation to the earlobe. Examination of the cervical spine showed active extension X limited with pain to posterior right side of the neck. Active side bending was X limited on right and X limited on the left with tightness. Rotation was X limited on the left with tightness. Tenderness to palpation was noted in right pectoralis minor, globally to anterior shoulder, over incision, and right anterior and middle deltoid. Hypomobile grade X right scapular mobilization in all directions was noted. There was slightly depressed right shoulder compared to the left. The activity limitations included pulling cabinets off the line, pushing / pulling X pound cabinets, lifting / carrying X pounds, and reaching overhead for lever to lower cabinets. The fear avoidance components scale score on X was X (moderate). The Quick Disabilities of the Arm, Shoulder and Hand score was X (X functional ability) and Quick Disabilities of the Arm, Shoulder and Hand score was X functional ability). X had not met any of the short term goals.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The claimant has received extensive prior care (some X documented treatments), i.e., care in excess of the X. ODG further stipulates that continuation of treatment is contingent on evidence of continued functional progress being made in individuals who have not yet reached maximum medical improvement (MMI). In this case, however, work restrictions remain in place. The claimant was not working with said limitations in place. Heavier lifting, carrying, pushing, pulling, reaching, and overhead reaching activities remain problematic. All of the foregoing, taken together, suggested that the claimant has likely plateaued from a functional perspective with prior care. Additional treatment is unlikely to be beneficial here. Therefore, the request for X is not medically necessary."

Per a reconsideration review adverse determination letter dated X by X, MD, the request appeal for X was denied. Rationale: "The ODG recommends X. In this case, the claimant was X. X stated X right shoulder pain level was X. X complained of a lot of stiffness. Overall, the symptoms had increased. There was increased pain at the time X felt due to cold weather. Upper extremity weakness remained the same. On examination, the range of motion (ROM) of right shoulder was the same. There was the same diffuse tenderness to palpation (TTP). The ROM revealed abduction of 90 degrees, flexion increased to X degrees, external rotation remained same of X degrees. The muscle testing decreased. The impingement test was positive. X continued to have limited ROM to just about shoulder height and decreased strength. A review of x-ray of right shoulder taken at the time revealed no fracture no dislocation / moderate degenerative joint disease (DJD). A review of an MRI of right shoulder dated X revealed X. The claimant had exhausted X. As such, the request for Appeal for X, is not medically necessary."

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient recovering from X. While the patient has had significant therapy since their injury, they still have major functional limitations for X. While it is possible the patient may X. X Appeal 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.

Patient recovering from X. While the patient has had significant therapy since their injury, they still have major functional limitations for which X. While it is possible the patient may X. 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:

- 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