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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. X sustained the injury while at work during a X. The diagnosis was pain in left hip (X); other abnormalities of gait and mobility (X); muscle weakness (generalized) (X); cervicalgia (X); and pain in left shoulder (X).On X, X was evaluated by X, PT, DPT, for a physical therapy progress visit for the diagnoses of pain in left hip (X); other abnormalities of gait and mobility (X); muscle weakness (generalized) (X); cervicalgia (X); and pain in left shoulder (X). X continued to have pain to the left hip when at rest, but X noted that function with standing transitions from a sitting position had been improving. X had been able to walk for longer distances without the use of an assistive device (AD) where X had stationary objects to hold onto, but X felt unstable while completing such tasks. X also noted having continued discomfort when lying on the left side to both left hip and cervical spine / left shoulder. X would notice pain to the left cervical spine that remained constant, but X felt that dizziness had been improved over the past few weeks. X also noted having continued pain to the left shoulder along with tingling / numbness into the left hand that remained constant. X also felt X was not ready to resume driving activities due to pain to the left hip and shoulder along with anxiety of returning to such activity. X had follow-up with the surgeon in X. Regarding functional activity status, X was unable to perform recreational exercise and driving. X had severe limitation with working and moderate limitation with walking, bending, and reaching. Examination noted X was able to ambulate with improved left lower extremity weightbearing using a X at the time. Sit-to-stand transitions were modified independent with X. X sat with improved posture. Cervical spine active range of motion (AROM) revealed X flexion, X extension, X right and left side bending, X right rotation, and X left rotation. Hip passive range of motion (PROM) testing was painful throughout and revealed flexion X degrees, abduction not tested, internal rotation X degrees, and external rotation X degrees on the right; and flexion X degrees, abduction and internal rotation X degrees, and external rotation X degrees on the left. Strength testing in the right hip revealed X strength in the gluteus maximum, gluteus medius, and hip flexors; and X in the hip medial and lateral rotators, hamstring,

and quadriceps. Strength testing in the left hip revealed X strength in the gluteus maximus and hip medial rotators, X strength with pain in the hip lateral rotators, X strength in the gluteus medius and hip flexors; X strength with pain to lateral left hip in the hamstring and quadriceps; and X strength in the tibialis anterior and peroneus longus. Lumbar spine slump test and neurotension test was X on the left. Shoulder AROM revealed flexion of X degrees with pain on the right and X degrees with pain on the left, and abduction of X degrees on the right with pain and X degrees on the left with pain. Shoulder PROM showed flexion and abduction of X degrees with pain bilaterally, internal rotation X degrees on the right and X degrees on the left, and external rotation X degrees bilaterally. Right shoulder strength testing revealed X strength in the biceps, triceps, and infraspinatus, X strength with pain in the subscapularis and deltoid middle, X strength in the supraspinatus, and X in the interscapular musculature. Left shoulder strength testing revealed X strength with pain in the biceps, infraspinatus, subscapularis, supraspinatus, and deltoid middle; X strength in the triceps; and X in the interscapular musculature. Hawkins impingement test was X on the left, and Speed's test was X. X was tender to palpation on the left hip, left-sided lumbar paraspinals, and tensor fascia lata (TFL) musculature on the left with palpation. There was tenderness to palpation of the bilateral upper trapezius, levator scapulae, sternocleidomastoids, cervical paraspinals, and suboccipital musculature (left greater than right). It was noted that X presented initially with left hip pain due to injury X sustained during a X. X also reported significant pain to the left-sided cervical spine and shoulder, stemming from the original fall. X reported slight improvements in pain levels to the cervical spine while also demonstrating improved left shoulder and cervical spinal AROM, PROM to left hip, and left lower extremity muscle strength, but X remained significantly limited with gait, standing, and sitting activities due to pain to the lateral left hip and cervical spine / left shoulder. Due to ongoing and remaining limitations, X remained an excellent candidate for X. X recommended X. On X, X presented for X reporting some irritation to the left hip prior to the appointment. X tolerated progression of weightbearing exercises completed that day with only reports of fatigue to hip stabilizer musculature throughout the visit. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "The request for X is not recommended as medically necessary. The mechanism of injury is not described. There is X. There is no X. There is no information provided regarding X. There are

no X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. “Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “Regarding X, ODG recommends X. X may be indicated when functional progress has been made during X. When treatment duration and/or number of visits exceeds the guideline recommendation, exceptional factors should be noted. In this case, the claimant previously underwent X. The claimant was also treated with X. The review of the claim indicates that the claimant has been approved for X. There is no evidence of X. Additional approval will require evidence of objective and functional progress with the need for X. Further, the requested X. Moreover, the records provided do not reflect exceptional factors that would suggest the need for treatment outside guideline recommendations. The request is not medically necessary. Therefore, the request is denied. “Thoroughly reviewed provided records including provider notes and peer reviews. The patient is still recovering from left hip injury and surgery. Left hip pathology complicated by left shoulder pain issues. The therapist is documenting objective functional improvement. Thus, further X may be indicated as variance to Guidelines. However the amount requested may be excessive and unclear why patient cannot transition to a X. It is also unclear if there are significant extenuating circumstances for patient’s delayed recovery. Thus, request may be X. X 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 The patient is still X. Left hip pathology complicated by left shoulder pain issues. The X is documenting objective X. Thus, further X may be indicated as variance to Guidelines. However the X. It is also unclear if there are significant extenuating circumstances for patient’s delayed recovery. Thus, request may be X. medically necessary and certified and the remaining X not medically necessary and non-certified
Partially 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)**