

Amendment Date:

Notice of Independent Review Decision

IRO Case number:

Description of the services in dispute

X

Description of the qualifications for each physician or 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:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

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

The claimant is X who was injured on X while X, for which X was diagnosed with a rupture of X left bicep tendon, strain of muscle of upper limb, tendinitis of left biceps brachii, and pain of left shoulder joint. X additionally hurt X left shoulder and neck. The claimant-initiated X. After X the claimant still complained about the pain and limited movement of X arm. This review is to determine the medical necessity of a request for X.

MRI of the Left Shoulder from X dated X documents "X. The tear involves X. Moderate grade X. The tear Involves X. No X.X.

Medical Report from X dated X stated "it's recommended with my professional opinion to proceed with X as X would not benefit from X at this time. X has not seen any improvement with any conservative treatment given the severity of X rupture thus far. Active/active assist mobility will likely worsen the traumatic injury causing

significant pain and decreased function. X is unable to do activities without any pain. The patient is unable to return to X. This will help avoid risk of further injury until X. Clinical Notes document that the claimant has been on X.

Operative vs non-operative treatment was discussed for X. After consideration of X options, the claimant stated X.

Denial Letter from X denied the request for X. It was stated "It was determined that the request still does not meet medical necessity guidelines. The UR Number for this request is X and no additional information is required from you at this time. The request below has been reviewed by a Physician Advisor not involved in the initial review, X, who holds a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving. A X performs X reviews and a X licensed in Texas performs X health care reviews, As the requesting provider, you were provided a reasonable opportunity to speak with the Physician Advisor regarding the appeal request prior to this determination being rendered".

Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision

The claimant is a X who was injured X. X was injured when X. X was diagnosed at that time with an acute left biceps tendon rupture, proximal, with strain of muscle of the upper limb and tendinitis of the biceps brachii on the left side in a painful shoulder joint. The claimant did X but still complained about pain and movement that was limited. The request at this point by the treating X was reconsideration of X. Based on the X, it is my professional opinion that the broad reaching request for X is in fact, two broad reaching. A specific diagnosis of X has not been established. Therefore, the specific requests to X are not indicated based on any presented objective criteria. The MRI does reveal a X. This fact also negates any indication for a X. The MRI also X. These X response to the injury documented. Therefore, with lack of association and lack of significant AC joint arthritis, the request for X is also not indicated. The MRI does X. The MRI states X. There was no mention in the notes of clinical significance or association with this MRI finding that was noted. No specific clinical findings such as a X were noted in the clinical record. The MRI also X. There is appropriately no request to X. The X are usually performed in conjunction with management of a X. No such X injury was mentioned or determined to be indicated for surgical intervention. This fact also supports a lack of indication for X procedures previously denied.

In summary, the current denial is upheld in its entirety. None of the X procedures are indicated. The more commonly indicated request to manage a X was not requested as X. A request for reconsideration of X. It is determined that X still does not meet medical necessity guidelines. The denial is upheld.

Description and source of the screening criteria or other clinical basis used to make the decision

- ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase
- AHRQ - Agency for Healthcare Research and 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
- ODG - Official Disability Guidelines & Treatment Guidelines

1. ODG Guideline: X.

- 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)