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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 is a X who was injured on X. X was a nurse caring for special needs students in the classroom. X was attacked by a student. X held X hands up to defend X and they grabbed X right arm and threw it down. The diagnosis was pain in right shoulder and cervicalgia. On X, X, NP evaluated X. X was seeing Dr. X with Seton Orthopedics; waiting on approval for X. X was attacked by a student. X held X hands up to defend X and they grabbed X right arm and threw it down. X had some pain with certain movements, had some numbness in X arm when X woke up and pain radiating down the arm. Pain was up to the shoulder. Motrin had not really helped. at that time, X presented for re-evaluation and reported no change in symptoms since the previous visit. X had a Designated Doctor Evaluation (DDE) on X and was found to be not at maximum medical improvement (MMI) but proposed MMI was on X. Designated Doctor recommended further care, specifically orthopedic evaluation, additional physical therapy, and potential injection. X was pending authorization for the X but had not heard regarding scheduling. X continued to have tingling to

the right thumb, 3-5th digit (circumferential) and tightness to the dorsal thumb. X continued to have limited range of motion of the right shoulder; felt like it got stuck with abduction and could only elevate the arm to shoulder height. X was not working at that time, noting X employer was not able to accommodate restrictions as X was a nurse caring for special needs students in the classroom. X was doing home exercises and noted stiffness and some discomfort with looking down. Examination noted tenderness of the right proximal upper extremity, tender anterior shoulder. Reduced active range of motion of the shoulder was noted with flexion reduced to 170/180 degrees, abduction reduced to 90/180 degrees, internal rotation reduced posterior reach to buttock, and limited cross body movement. Hawkins', Neer's, and empty can tests were normal. The assessment was impingement syndrome of right shoulder and unspecified sprain of right shoulder joint. X was to continue home exercises and light duty restrictions. X was pending authorization for X. Per a No Visit Discharge note by X, PT, dated X, X diagnoses were pain in right shoulder and cervicalgia. X first attended physical therapy on X and last attended on X. X had X. X was discharged by Workers' Compensation. An MRI of the right shoulder dated X, revealed intact rotator cuff and suspected focal superior labral tear from anterior to posterior (SLAP) type I tear of the posterior superior glenoid labrum. Treatment to date included medications (X), X, and X. Per a utilization review adverse determination letter dated X, the request for X as requested by X, MD at Ascension Medical Group Seton Orthopedics, was denied by X, DO. Rationale: "Regarding physical therapy, as stated in the guidelines, physical medicine is recommended, and the given frequency should be tapered and transition into a self-directed home program. The ODG by MCG guidelines allow for fading treatment frequency (from up to three visits per week to one or less), plus active self-directed home physical therapy. The guidelines indicate that for sprained shoulder and rotator cuff tears: medical treatment, sprain: ten visits over eight weeks is appropriate. In general, the use of active treatment modalities instead of passive treatment modalities is associated with substantially better clinical outcomes. The most commonly used active treatment modality is therapeutic exercise, but other active therapies may be recommended as well, including neuromuscular re-education, manual therapy, and therapeutic activities/exercises. The clinical summary states that prior treatment includes X with limited measurable functional benefit as there was still pain, pain with motion testing, and subjective numbness and tingling. It is recommended that therapy should be tapered and transition into a self-directed home program. In this case, it is unclear what extraordinary circumstances exist in which it would be necessary for claimant to have additional therapy in excess of the guideline recommendation. It is unclear why the claimant cannot be directed to a self-home exercise program by now as there are no barriers to a self-home exercise program or recent exacerbations documented. The request is noncertified. "Per a reconsideration review adverse determination letter dated X, the appeal request for X as requested by X at Ascension Medical Group Seton Orthopedics, was denied by X, MD. Rationale: "The Official Disability Guidelines conditionally recommend X for sprained shoulder. In this case, the patient complained of right forearm pain. right thumb tingling and tightness and reduced right shoulder range of motion (ROM) and the provider noted tenderness of proximal upper extremity and reduced shoulder ROM on the physical exam. Prior treatments include medications and X. The treating provider recommends X. There is no evidence that showed the patient's improvement with the previous sessions. In addition, the request exceeds the Guidelines recommendations. As such, the request for APPEAL X, is noncertified. Thoroughly reviewed provided records including provider notes and peer reviews. While patient still has some pain and functional deficits involving the affected shoulder, they did make some progress with physical therapy. Thus, further therapy requested is reasonable and warranted. Further, designated doctor exam, orthopedics, as well as physical therapist are all recommending further therapy as the primary treatment. 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.
While patient still has some pain and functional deficits involving the affected shoulder, they did make some progress with physical therapy. Thus, further therapy requested is reasonable and warranted. Further, designated doctor exam, orthopedics, as well as physical therapist are all recommending further therapy as the primary treatment. X is medically necessary and certified Overturned

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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)**