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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 Overturned (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 stated X was pulling a 30-foot hose that had a kink in it, and when the hose unrolled, it pulled X left shoulder and arm up and backwards. The diagnosis was strain of unspecified muscle, fascia, and tendon at shoulder and upper arm level, left arm; pain in left shoulder; and unspecified injury of muscle(s) and tendon(s) of the rotator cuff of left shoulder. On X, X was seen in follow-up via telemedicine by X, NP for X, MD. X reported the pain in the left shoulder at rest was 2-3/10 and active 10/10. Physical therapy had seen X and stated X got a shot that had helped X a bit. X stated that overall, the symptoms had decreased and reported a pain level of 3/10. X stated the range of motion had increased and numbness and tingling had decreased. Upper extremity had decreased. On examination, the left shoulder revealed the diffuse tenderness had decreased. Tenderness anterior, posterior, and in the bicipital groove had decreased. Range of motion showed abduction, flexion, and internal and external rotation had increased. Muscle testing was improving. Positive impingement and positive sulcus sign were noted. Review of left shoulder x-rays from X was negative for fracture or dislocation. Review of an MRI of the left shoulder dated X, showed low-grade partial-thickness supraspinatus, subscapularis, and intra-articular long head biceps tendon tears. There was moderate glenohumeral joint osteoarthrosis with circumferential tearing of the labrum and associated 1-cm inferior labral cyst. Mild acromioclavicular joint osteoarthrosis was seen. The plan was to take over-the-counter medication as needed – X. X had second opinion orthopedic visit on X, and received X. X were recommended. The reason for X was: post-injection therapy, to improve range of motion and function. Restricted duty work status was continued. Review of left shoulder x-rays from X was negative for fracture or dislocation. Review of an MRI of the left shoulder dated X, showed low-grade partial-thickness supraspinatus, subscapularis, and intra-articular long head biceps tendon tears. There was moderate glenohumeral joint osteoarthrosis with circumferential tearing of the labrum and associated 1-cm inferior labral cyst. Mild acromioclavicular joint osteoarthrosis was seen. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X

was denied by X, DO, as not medically necessary or appropriate. Rationale: “Medical documentation indicates the claimant has had shoulder pain with a reduced range of motion and reduced function. The claimant has completed X with some mild improvement. X job requires heavy work, a lot of lifting, pushing, and pulling. The claimant is unable to go back to it. X is anxious to get back to work. The claimant feels X is essentially X and wants another opinion which is in the process of occurring. In this case, the nurse practitioner states that the claimant recently saw an orthopedic surgeon Dr. X, who diagnosed capsulitis and recommended X. The claimant is not happy with that diagnosis and does not want to do X until X sees another orthopedic surgeon for a second opinion because it appears that X is not providing any significant improvement. The nurse practitioner indicated that X is in the process of setting up another second opinion with an orthopedic surgeon. The claimant has been in home exercises and is doing them on a regular basis. As such, the request for X as an outpatient, is not medically necessary. “Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “As per ODG, "X." In this case, this request is for a X who reported experiencing left shoulder pain on X when X left arm became hyper-extended when a 30-foot hose X was moving unexpectedly recoiled. Initial X-rays were normal. According to a X recheck visit note following X, the claimant continued to experience left shoulder pain ranging from 3-8/10, with increased LUE paresthesia along the ulnar nerve distribution. PMH - diabetes. MRI on X showed low-grade partial thickness supraspinatus and subscapularis tears, an intraarticular biceps tear, degenerative labral tearing, and arthritis of the GH and AC joints. According to a X follow-up visit after X, the claimant had seen an orthopedist on X who performed an injection and recommended X, but specific therapeutic objectives for which additional X were not documented. ODG supports X for medically treated RTC injuries and X. Peer contact was attempted without success. Therefore, the request for appeal request for X is not medically necessary. “Thoroughly reviewed provided records including provider notes and peer reviews Patient with continued pain and functional deficits noted involving left shoulder in relation to rotator cuff pathology. The patient has been seen by multiple providers regarding this issue and has been treated primarily with PT. While the cited guidelines support up to X, the patient has either reached or is close to reaching this amount. However, the patient had recent shoulder injection and PT is still being

considered as a primary treatment. While the patient may consider home exercise program (and they have been doing so), X may have additional benefits following an injection in terms of use of modalities as well as having a trained PT work on strengthening and ROM exercise with patient. Notably, the cited guidelines do recommend X. Thus, at least X appear warranted. X partially overturned to X certified and the remaining X not medically necessary and uncertified

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 with continued pain and functional deficits noted involving left shoulder in relation to rotator cuff pathology. The patient has been seen by multiple providers regarding this issue and has been treated primarily with PT. While the cited guidelines support up to X, the patient has either reached or is close to reaching this amount. However, the patient had X is still being considered as a primary treatment. While the patient may consider home exercise program (and they have been doing so), formal PT may have additional benefits following X in terms of use of modalities as well as having a trained PT work on strengthening and ROM exercise with patient. Notably, the cited guidelines do recommend X. Thus, at least X appear warranted. Additional X is partially overturned to X medically necessary and certified and the remaining X not medically necessary and uncertified
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)**