PO Box 519
Schertz, TX 78154

IRO Certificate No: x

Notice of Workers' Compensation Independent Review Decision

x

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

x

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

x

PATIENT CLINICAL HISTORY [SUMMARY]: This case involves a now X patient who sustained a left shoulder injury on X, status post capsular release and manipulation on X who developed multiple medical conditions post-surgery that includes X. Various treatments and evaluations were continued over the course of medical treatment associated with left shoulder pain which includes the following medications of: X.

The patient incurred a left shoulder injury on X from X. X-ray on X was X. Magnetic resonance imaging (MRI) of the left shoulder on X suggested X. On X, the patient was seen at X, diagnosed with impingement syndrome and adhesive capsulitis who was recommended X. The patient returned to work with limitations in X but with noted pain and limited range of motion. On X, a second X was provided. Due to continued symptoms of pain on left shoulder, the patient underwent X on X who had post-operative complication of X. X were done with noted improvement. On X, the patient was identified with limited strength and X was recommended. X, done on X showed X. ON X, MRI showed similar findings that included possible X. On X, X was done with findings X. On X, X were noted with no neural involvement. X on X showed X. On X, evaluation was done on the X. The patient recommended follow-up X, X consult was done on X and another X was

recommended. On X, designated doctor examination was conducted that showed the patient reached statutory maximum medical improvement on X with X whole person impairment rating. On X, the patient was evaluated with X and was diagnosed with left shoulder strain with surgery and brachial plexus injury. X was initiated. On X, X was done wherein the patient stated relief of symptoms for X months and was repeated on X. The patient was recommended for X wherein initial consultation done on X received a recommendation for X. Peer review report dated X identified unclear findings relating X for the treatment of X.

On X, a Request for Reconsideration was completed by X, MD. A letter for reconsideration was submitted. The patient is noted with continued shoulder pain with pain rate of X. Reported waking up at times with the last X digits of the left hand numb when sleeping on that left side. Reported that medications provided symptomatic relief. The patient is seen for X. Noted having incurred X with date of injury of X. It was noted that Medical provider (Dr. X) recommended continued use of X. The patient needs the X due to ongoing complaints of shoulder pain. The X is needed due to the patient X. X is used for the patient's X. X due to associated pain. X helped with X. X is used to address the mechanical nature of the patient's shoulder.

On X, a Peer Review Report was completed by X, DO. As per conducted peer review, the patient's date of injury is noted to be X however with undocumented mechanism of injury. The patient is with diagnosis of left brachial plexopathy and small intestinal bacterial overgrowth (SIBO). Noted submitted indicated the patient had shoulder pain and left-hand numbness in the last X digits. There was no physical examination findings listed. Documentation showed need for X for shoulder pain, X for X, X for neuropathic pain, X to help with sleep, X that helped with shoulder X related pain and X for

ongoing mechanical nature of shoulder pain. However, it was identified that the request for X was without documentation detailing what specific overall functional efficacy has been achieved with this treatment, the request for X had no documentation detailing overall functionality of this medication despite reportedly effective with X pain, the requested X is a medication identified to be indicated for X however, this is not documented on clinical records, the requested X is found to be not recommended for long term use and is only for short term usage as per guidelines and the patient's Clinical records does not indicate short term use and lastly, the requested X has no documentation detailing overall functionality and as to why an over the counter (OTC) X could not be used. With these, the requested medications are clinically not supported that led to denial of coverage. Basis of denial is from the Official Disability guidelines (ODG) used by the reviewer to support denied services.

On X, a Notice of Adverse Determination Letter was completed by X. The letter indicated that the requested services did not meet established standards of medical necessity. With this, non-certification was issued in the request of X medically necessary and X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The Official Disability Guidelines indicate that X may be indicated when all of the following are present: X.

The Official Disability Guidelines indicate that X is not recommended for long term use but is recommended for short term use.

The Official Disability Guidelines indicate that X is indicated when all of the following are present: X.

The Official Disability Guidelines indicate that X.
Evidence based literature indicates alternative therapies such as X use have been used to X. However, findings show existing studies lacked standardized formulations of treatment with lacking robust clinical trials that support long term use as X.

In this case, the patient sustained a work-related injury to the left shoulder on X, after pulling on a X. A X was performed on X, after which the patient developed a post-operative X. Multiple rounds of X were administered, which subsequently led to X. As a result, X was recommended. The patient underwent various treatment modalities, including X. Numerous diagnostic evaluations were conducted, and multiple specialists were consulted to manage the persistent shoulder pain. According to the Official Disability Guidelines (ODG), X is approved for osteoarthritis but not recommended if the patient is already taking another X. Clinical records indicate the patient is using an X. X is indicated for short-term use, yet the clinical documentation shows chronic use. X (X) is also not recommended with X, which is present in this case. X used for neuropathic pain, lacks clinical documentation demonstrating its impact on functional improvement. Additionally, peer review findings indicate that the use of X for treating X lacks sufficient

evidence from robust clinical trials and does not have a X. Based on these considerations, the requested medications of X are not medically supported. As such, denial of X are upheld as not medically necessary.

SOURCE OF REVIEW CRITERIA:

- ACOEM – American College of Occupational & Environmental Medicine UM Knowledgebase
- 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
- ☒ ODG- Official Disability Guidelines & Treatment 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)

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)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

X.