

**US Decisions Inc.**

***Notice of Independent Review Decision***

Case Number: X

Date of Notice: X:Amendment X

---

**US Decisions Inc.**

**An Independent Review Organization**

**3616 Far West Blvd Ste 117-501 US**

**Austin, TX 78731**

**Phone: (512) 782-4560**

**Fax: (512) 870-8452**

**Email: [@us-decisions.com](mailto:@us-decisions.com)**

***Notice of Independent Review Decision***

***Amendment X***

**IRO REVIEWER REPORT**

**Date:** X:Amendment 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)

## US Decisions Inc.

### *Notice of Independent Review Decision*

Case Number: X

Date of Notice: X:Amendment X

---

- 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, which was actually the result of a X. X had to X. At times, the door would hit X on X left shoulder. As a result of that, X developed pain in the left shoulder as well as numbness in the left hand and pain in the back of the arm. The diagnosis was left brachial plexopathy. On X, X presented to X, MD, for follow-up evaluation. X stated that overall, X continued to do the same with some more pain because X had been rationing X medications because X had been losing all the appeals on X medications. X continued with shoulder pain and X pain level was about a X. X medication continued to help when X was able to take them and X had no issues with them. X presented for refill of X medications with X and then Dr. X would see X back in X months. Left shoulder examination was essentially unchanged as follows: There was mild tenderness to palpation diffusely, with tenderness also noted in the X. There was X.

## US Decisions Inc.

### *Notice of Independent Review Decision*

Case Number: X

Date of Notice: X:Amendment X

---

There was X. Left shoulder range of motion showed forward flexion of X degrees, abduction of X degrees, external rotation of X degrees, and internal rotation of X degrees. X still could not actively lift X arm above X degrees. Motor examination revealed left shoulder abduction at X. Reflexes were X. The assessment was left brachial plexopathy. X was to continue X. X was given a X. Treatment to date included X. Per a utilization review adverse determination letter dated X and a peer review report dated X by X, DO, the request for X was denied as not medically necessary. Rationale: "The X. While the claimant has a left brachial plexopathy and dysfunction, the X. There was no mention of a X. Given the claimant's circumstances, and the guidelines, there is no support for the requested X. Therefore, the request for X are not medically necessary. "Per a reconsideration review adverse determination letter and a peer review report dated X by X, MD, the appeal request for X, was denied. Rationale: "The previous utilization review on X was denied, stating that the X. There was no mention of a X. According to guidelines, there is not sufficient recommendation for the use of X. Per ODG, "X." Not recommended as a first-line option; evidence shows inconclusive benefit, lack of benefit, or potential harm." "X is NOT recommended for any of the following: Shoulder disorder (3)." Given the lack of evidence of X, is non-certified. Therefore, the requested appeal for X, is upheld and non-certified." "As the X was not supported, this related appeal request for X is upheld and noncertified." Thoroughly reviewed provided records including provider notes and peer reviews. The ODG recommendations state X are recommended as an option; may be a first-line or second-line option. The claimant with chronic pain issues involving the left shoulder that may be related to brachial plexopathy. Dr. X wrote an extensive letter in X that does not appear to

## US Decisions Inc.

### *Notice of Independent Review Decision*

Case Number: X

Date of Notice: X:Amendment X

---

be discussed in peer reviews. The claimant has been using X with success resulting in some relief of their shoulder pain and allowing the claimant to regain some functional independence. Regardless of whether or not the claimant needs independent X functionality, the claimant has clear benefit from this X thus continued use is medically necessary. 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. The ODG recommendations state X are recommended as an option; may be a first-line or second-line option. The claimant with chronic pain issues involving the left shoulder that may be related to brachial plexopathy. Dr. X wrote an extensive letter in X that does not appear to be discussed in peer reviews. The claimant has been using X with success resulting in some relief of their shoulder pain and allowing the claimant to regain some functional independence. Regardless of whether or not the claimant needs independent X functionality, the claimant has clear benefit from this X thus continued use is medically necessary. X is medically necessary and certified

Overturned

**US Decisions Inc.**

***Notice of Independent Review Decision***

Case Number: X

Date of Notice: X:Amendment X

---

**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)**

**US Decisions Inc.**

***Notice of Independent Review Decision***

Case Number: X

Date of Notice: X:Amendment X

---

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**