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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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who sustained an injury on X. The diagnoses included sprain of left rotator cuff capsule, initial encounter; bicipital tendinitis, left shoulder; and impingement syndrome of left shoulder.

There are no medical records available for review other than X utilization reviews.

Per the utilization review by X, MD on X, the request X was non-certified. Rationale: "In this case, the injury was sustained when the patient X. The patient presents for evaluation of left shoulder pain following a fall on X. Since the injury, the pain has progressively worsened, with the most severe pain localized across the anterior aspect of the left shoulder. Additional pain radiates across the posterior shoulder and upper back. Sleeping has been particularly challenging due to discomfort. The patient has been X. The patient has been performing minimal tasks at work as part of a return-to-work program, including labeling and handling small items. The patient describes occasional attempts to improve mobility by crawling their hand up surfaces. Examination of the left shoulder reveals minimal swelling. A faint residual bruise is noted in the same area. Range of motion testing demonstrates X. ER with corresponding weakness. X) but with pain. Prior Treatment: X. The requested X procedure is not medically necessary. The submitted medical records do not demonstrate that the patient has attempted an appropriate course of X. Thus, the guidelines have not been met. Therefore, the requested X, is not medically necessary." X was non-certified. Rationale: "In this case, the injury was sustained when the patient X, fell on the right

buttocks/rolled/landed on the left elbow/ripped on left shoulder, limited mobility/swelling. The patient presents for evaluation of left shoulder pain following X. Since the injury, the pain has progressively worsened, with the most severe pain localized across the anterior aspect of the left shoulder. Additional pain radiates across the posterior shoulder and upper back. Sleeping has been particularly challenging due to discomfort. The patient has been X. The patient has been performing minimal tasks at work as part of a return-to-work program, including labeling and handling small items. The patient describes occasional attempts to improve mobility by crawling their hand up surfaces. Examination of the left shoulder reveals minimal swelling. A faint residual bruise is noted in the same area. Range of motion testing demonstrates decreased X. ER with corresponding weakness. Full passive range of motion (PROM) but with pain. Prior Treatment: X. As the X request is not medically necessary, the X request is not indicated. Therefore, the requested X is not medically necessary.”

Per the utilization review by X, MD on X, the appeal request for X was upheld. Rationale: “In this case, the MRI for the left shoulder is X. There is an X. Although the documentation does not indicate that X. Addressing the X would be appropriate. The request for X is medically necessary. However, there are insufficient objective and imaging findings documented to support the X is not medically necessary. As there was no successful peer-to-peer discussion for the treatment modification, the appeal request is recommended upheld.” Post-op X: X is upheld based on the following: “This request was previously denied by X, MD as the X request is not medically necessary. The ODG by MCG supports the use of a X. However, as there was no successful peer-to-peer discussion for the treatment modification, the appeal request is recommended upheld.”

The requested X is not medically necessary. The submitted medical

records do not demonstrate that the patient has attempted an appropriate course of X. There are insufficient objective and imaging findings documented to support the X, as such, the X is not medically necessary. No new information has been provided to overturn the previous denials. X are not medically necessary and non-certified.

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

The requested X procedure is not medically necessary. The submitted medical records do not demonstrate that the patient has attempted an appropriate course of X. There are insufficient objective and imaging findings documented to support the X, as such, the X is not medically necessary. No new information has been provided to overturn the previous denials. X are not medically necessary and non-certified.

Non-Certified.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE