Applied Resolutions LLC

Notice of Independent Review Decision

Applied Resolutions LLC
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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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is X who was injured on X. X slipped while trying to step out of the truck. X fell on the front side with left arm in fall on outstretched hand (FOOSH) position. X fell on asphalt and had immediate pain in left shoulder. The diagnoses were left shoulder strain, left shoulder partial-thickness supraspinatus tear and left shoulder stiffness.

On X, X was seen by X, MD for evaluation of left shoulder pain. X initially injured X shoulder while at work on X. X slipped while trying to step out of X truck and fell directly onto X left side and left arm. X had immediate left shoulder pain, discomfort, and limitations in range of motion. X was initially seen and evaluated on X where x-rays were obtained and demonstrated no acute fractures. X was recommended X. X obtained an MRI later that month which demonstrated a partial tear or the supraspinatus. X was seen by an Orthopedic Surgeon who recommended a X. X noted some initial relief from X but overall continued to have symptoms. Unfortunately, X continued to have pain and discomfort. X was recommended additional X in X but that was declined. Recently, X noted worsening left shoulder pain and discomfort. X pain was localized to the anterior and lateral aspect of the shoulder. X had difficulty with lifting X arm overhead. X had functional limitations with pain daily with lifting, reaching, pushing, and pulling. X had been taking anti-inflammatory medications (X over-the- counter), modifying X activities and doing some home exercises that X learned from physical therapy. X denied any radiating left upper extremity pain or numbness or tingling. Examination of left shoulder showed tenderness to palpation of greater tuberosity. Active flexion to 120 degrees, passive flexion to 150 degrees, passive external rotation to 40 degrees and active internal rotation “SP.” Strength in supraspinatus was 4/5 (weakness with resisted abduction). Drop arm test and empty can test were positive. Strength in infraspinatus was 5/5 with pain with resisted testing. Hawkin’s impingement test and Neer test were positive. X-ray of

the left shoulder done that day showed a well-centered glenohumeral joint on the AP and axillary lateral views. There was no evidence of arthritic changes, fractures or dislocation. X had left shoulder pain and discomfort. X had shoulder pain with functional limitations in X activities of daily living. X had the inability to fully elevate the arm overhead and had reduced shoulder range of motion. X had some weakness on examination as well as pain with resisted testing. X had undergone formal supervised physical therapy but had not done physical therapy in quite some time. X had been using anti-inflammatory medications, home exercise program, and modifying X activities. Given X ongoing pain and discomfort which X noted had been worsening over the past few months, a X was recommended to evaluate the status of X rotator cuff and to evaluate for possible progression of X tear.

Per a Report of Medical Evaluation dated X, Xe, MD stated that X had reached clinical maximum medical improvement on X with no permanent impairment as a result of the compensable injury.

An MRI of the left shoulder dated X revealed insertional tendinosis and partial-thickness undersurface tear of the supraspinatus tendon, proximal to the insertion. Insertional tendinosis of the subscapularis tendon was noted without focal tear. Subdeltoid and subcoracoid periarticular bursitis was noted.

Treatment to date included X.

Per a Peer Review Report dated X, the request for X was denied by X, MD. Rationale: “ODG by MCG Last review/update date: X Shoulder MRI Treatment type: Diagnostic Testing, Imaging "Conditionally Recommended-CR Recommended as an option; may be a first-line or second-line option. ODG Criteria Repeat evaluation of specific area or structure with same imaging modality, and ALL of the following: X. The baseline is not documented in these new notes. There is no new injury. The patient has current pain, but in the past, the patient's pain was up to 10/10 as well. The patient has a partial-thickness tear, and there is no justification for how X would change the plan if an invasive

procedure is being considered. Recommend to deny based on ODG. Therefore, the request for X is non-certified."

Per another Peer Review Report dated X, the request for X was denied by X, MD. Rationale: "ODG by MCG Last review/update date: X. ODG Criteria Repeat evaluation of specific area or structure with same imaging modality, and ALL of the following: Clinical need for X, as indicated by 1 or more of the following: Change in clinical status (e.g., worsening symptoms or new associated symptoms), and findings may impact treatment Need for interval reassessment that may impact treatment plan. Need for X. The requested X is not medically necessary. The submitted records indicate the patient already obtained a X. No new injuries occurred. There has been no change in the patient's symptoms or objective findings. Thus, the guidelines have not been met. Therefore, the request for X is upheld and non-certified."

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a Peer Review Report dated X, the request for X was denied by X, MD. Rationale: "ODG by MCG Last review/update date: X. ODG Criteria Repeat evaluation of specific area or structure with same imaging modality, and ALL of the following: Clinical need for X, as indicated by 1 or more of the following: Change in clinical status (e.g., worsening symptoms or new associated symptoms), and findings may impact treatment Need for interval reassessment that may impact treatment plan. Need for X either prior to or after performance of invasive procedure Prior imaging results of specific area or structure with same imaging modality documented and available for comparison. The baseline is not documented in these new notes. There is no new injury. The patient has current pain, but in the past, the patient's pain was up to 10/10 as well. The patient has a partial-thickness tear, and there is no justification for how a X would change the plan if an invasive procedure is being considered. Recommend to deny based on ODG. Therefore, the request for X is non-certified." Per another Peer Review Report dated X, the request for X was denied by X, MD. Rationale: "ODG by MCG Last review/update date: X. ODG Criteria Repeat evaluation of specific area or structure with same imaging

modality, and ALL of the following: Clinical need for X, as indicated by 1 or more of the following: Change in clinical status (e.g., worsening symptoms or new associated symptoms), and findings may impact treatment Need for interval reassessment that may impact treatment plan. Need for X either prior to or after performance of invasive procedure Prior imaging results of specific area or structure with same X. The requested X is not medically necessary. The submitted records indicate the patient already obtained a X. No new injuries occurred. There has been no change in the patient's symptoms or objective findings. Thus, the guidelines have not been met. Therefore, the request for X is upheld and non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no documentation of a significant change in the patient's clinical presentation to support X. It is unclear how X would impact the patient's treatment plan when the prior X showed a partial-thickness undersurface tear of the supraspinatus tendon, proximal to the insertion. There is no documentation of a new injury. Therefore, medical necessity is not established in accordance with current evidence based guidelines. X is not medically necessary and non-certified

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

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per a Peer Review Report dated X, the request for X was denied by X, MD. Rationale: "ODG by MCG Last review/update date: X. The baseline is not documented in these new notes. There is no new injury. The patient has current pain, but in the past, the patient's pain was up to 10/10 as well. The patient has a partial-thickness tear, and there is no justification for how a X would change the plan if an invasive procedure is being considered. Recommend to deny based on ODG. Therefore, the request for X is non-certified." Per another Peer Review Report dated X, the request for X was denied by X, MD. Rationale: "ODG by MCG Last review/update date: X. The requested X is not medically necessary. The submitted records indicate the patient already obtained a X. No new injuries occurred. There has been no change in the patient's symptoms or objective

findings. Thus, the guidelines have not been met. Therefore, the request for X is upheld and non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no documentation of a significant change in the patient's clinical presentation to support X. It is unclear how X would impact the patient's treatment plan when the prior X showed a X. There is no documentation of a new injury. Therefore, medical necessity is not established in accordance with current evidence based guidelines. X is not medically necessary and non-certified
Upheld

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

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☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE