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## **Notice of Independent Review Decision**

**IRO Reviewer**

**Report X**

**IRO Case Number: X**

**Description of the services in  
dispute**

**X**

**Description of the qualifications for each physician or health care  
provider who reviewed the decision**

**X.**

**Review Outcome:**

Overtured (Disagree)

**Information provided to the IRO for review**

X

**Patient clinical history**

X individual diagnosed with impingement syndrome of the right shoulder and nontraumatic incomplete tear of the right rotator cuff, and seeking coverage for X.

X - Physical Therapy Re-Evaluation Note by X, PT - The patient reported improvement in right shoulder pain from a X work injury, with current pain at X. However, it increased with spontaneous movement and heavy lifting. Examination revealed X. The plan included X.

X - X - An MRI of the right shoulder revealed a X. Findings also included X. Additionally, X was noted.

X - Office Visit - The patient presented for an initial visit due to right shoulder pain, rated X, from a X work-related injury, reporting aggravation with movement. Examination showed a X. A X was administered, and a plan was made to continue X.

X - Medical and Surgical Authorization Request - A medical and surgical authorization request was submitted for the patient for X. The request included various CPT codes for X, to be performed X times per week for X weeks, totaling X visits. The services were requested for the period from X to X.

X - Office Visit - The patient presented for follow-up of right shoulder pain, a work-related injury from X, reporting persistent X pain despite a X. Examination revealed a X. The plan included X.

X - Notice of Approval - The patient's request for X. The approved services included specific CPT codes, with a requirement that at least X of the X

total units per session must be X. This approval was based on medical necessity criteria from the Official Disability Guidelines (ODG).

X - Office Visit - The patient reported ongoing right shoulder pain, rated X, radiating to the neck and aggravated by certain movements, following a work-related injury on X. Physical examination showed X. X, including X, was discussed, with the patient scheduled for X.

X - Physical Therapy Evaluation Note by X, PT - The patient was referred for X due to right shoulder pain, impingement syndrome, and upper trapezius muscle spasm following a work-related injury. Examination revealed X. The plan of care included X.

X - Office Visit - The patient presented for follow-up of right shoulder pain from a work-related injury, reporting persistent X pain despite X. Examination showed a X. The plan included X.

X - Physical Therapy Note by X, PTA - The patient reported persistent right shoulder pain limiting daily activities, with pain increasing with activity and decreasing with rest. Objective findings included X. The plan of care was to continue X.

X - Physical Therapy Note by X, PT - The patient reported persistent right shoulder pain that limited daily activities, with pain increasing with activity and decreasing with rest. Objective findings included X. The plan of care was to X.

X - Physical Therapy Note by X, PT - The patient continued to experience persistent right shoulder pain limiting daily activities, with pain increasing with activity and decreasing with rest. Objective assessment noted X. The plan was to X.

X - Physical Therapy Note by X, PT - The patient reported persistent right shoulder pain limiting daily activities, with pain increasing with activity and decreasing with rest. Objective findings included X. The plan of care was to X.

X - Physical Therapy Note by X, PT - The patient reported persistent right shoulder pain that limited daily activities, with pain increasing with activity and decreasing with rest. Objective findings included X. The plan was to X.

X Office visit - The patient presented for follow-up of right shoulder pain, a work-related injury from X, reporting persistent X pain despite X. Examination revealed X. The plan included X.

X - Peer/Medical Record Review - A peer review concluded that the patient's right shoulder MRI findings from X were degenerative and not related to the X work incident, which was deemed a resolved X. The review also cited peer-reviewed literature indicating that MRI findings for X.

X - Medical and Surgical Authorization Request - A request was submitted for the patient X. The diagnoses of impingement syndrome (X) and nontraumatic incomplete rotator cuff tear

(X). The orthosis request specified a period ending X. The facility for the X was listed as X.

X - Medical Review Request Form by X, MD - A medical review request form was submitted for the patient for X. The diagnoses listed were impingement syndrome of the right shoulder (X) and nontraumatic incomplete rotator cuff tear (X).

X - Notice of Adverse Determination - The requested X were denied as not medically necessary, based on Official Disability Guidelines (ODG). While X might have been supported, the X lacked imaging evidence of specific X. Consequently, the X was also deemed not medically necessary due to the denial of the X.

X Office visit - The patient presented for follow-up of right shoulder pain, a work-related injury, reporting persistent X pain and difficulty with overhead activities after X denied. Examination revealed a X. Despite the prior denial, the provider concluded the patient qualifies for X due to a near X.

X - Notice of Appeal - Adverse Determination - The appeal for X was denied as not medically necessary, as the requests in their entirety did not meet guidelines. While X alone was deemed medically necessary due to X. Without agreement to modify the treatment plan, the entire request was denied, and consequently, the X was also deemed not medically necessary.

X Medical Order by X, PA-C/X, MD - Medical orders were placed for a X for the patient. These orders, initiated on X, are for X. Both orders are currently in pending status.

X Medical and Surgical Authorization Request - A request was submitted for X for the patient. The requested services were for dates between X and X, with diagnoses of impingement syndrome (X) and

nontraumatic incomplete rotator cuff tear (X). The request was made by X and adjusted by X, with X as the facility.

**Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision**

The claimant is a X who sustained a work-related right shoulder injury on X. The planned procedure is X.

Official Disability Guidelines (ODG) criteria for X is conditionally recommended when X.

ODG criteria for X are indicated when an X.

Imaging support is present because the treating provider personally reviewed the X. Conservative care has exceeded X months and included X in X and a later additional course of X. The claimant continued to report significant pain rated X with radiation to the neck and difficulty with overhead activities. The most recent X evaluation documented X.

Based on the documented imaging findings, the prolonged X. As such, the denial is overturned.

**Description and source of the screening criteria or other clinical basis used to make the decision**

ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase

AHRQ - Agency for Healthcare Research and

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)