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An Independent Review Organization
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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 who sustained an injury on X while the claimant was lifting heavy objects at work. X heard a pop in X. The diagnoses included impingement syndrome of the right shoulder; strain of the muscle, fascia, and tendon of other parts of the biceps of the right arm; strain of other muscles, fascia, and tendons at shoulder and upper arm level of the right arm; rupture of rotator cuff of right shoulder; injury of biceps brachii muscle; tendinitis of right biceps brachii; subacromial impingement; subacromial bursitis of right shoulder; and sprain of ligament of right shoulder joint.

X was seen by X, MD on X for right shoulder pain. Since the Injury, X has experienced severe limitations in the use of X right shoulder, including pain, discomfort, and difficulty with overhead motion. X reported loss of strength and inability to lift heavy objects, which significantly impacted X ability to perform work-related tasks. Movements requiring lifting Items overhead or without discomfort were particularly challenging. X had been undergoing X for approximately X months with minimal improvement in shoulder function. X body mass index was 36.2 kg/m2. Right shoulder examination revealed X. Range of motion revealed flexion X degrees, abduction X degrees, and external rotation X degrees. There was X, Hawkins test, Neer's impingement test, and O'Brien's test. Strength was X in external rotation, internal rotation, and supraspinatus testing. Belly press and lift-off tests were X. The plan was for X.

An X of the right shoulder dated X, revealed X.

Treatment to date included X.

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Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “In this case, the diagnostic X is medically necessary and supported, while the additional procedures are not supported at this time based on the available documentation and guideline criteria. The claimant has persistent right shoulder pain with functional limitation, restricted range of motion, and X. X findings demonstrate X. According to the ODG Shoulder Section (updated X), diagnostic X is conditionally recommended when there is persistent dysfunction despite nonoperative care and indeterminate X findings, as it allows direct visualization to confirm or rule out structural pathology and guide definitive management. However, the request for X is not supported since there is X, which is required under ODG criteria. Similarly, X is not indicated, as imaging does not show a X. The request for X is also not supported, as ODG recommends this only for X, which is absent here. The X is not medically necessary at this time because imaging does not demonstrate significant X. Finally, the use of a X is not warranted for diagnostic X alone, as ODG permits X. Therefore, the request for X: X, as an outpatient is partially medically necessary to X only. The remaining procedures, including X, are not medically necessary based on the current evidence.

Per an utilization review by X, MD on X, the request for X was non-certified. Rationale: “In this case, the claimant has chronic right shoulder pain with severe limitations in the use of the right shoulder and loss of strength and has tried X. However, the X of the right shoulder conducted on X does not indicate X. Therefore, the request for X, as an outpatient is not medically necessary.”

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

Based on the submitted medical documentation, the requested X is not medically necessary. The submitted imaging report does not demonstrate the presence of a X. The requested X is not indicated as well given the lack of imaging findings to support X. A X is also not warranted given the lack of

pathology present on the X. The prior denials are appropriate. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified.

Non-certified.

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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