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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 was injured on X. X reported X was at work performing a X. X had significant pain, swelling, and decreased range of motion. The diagnosis was pain in right shoulder (X).

On X, X was seen by X, DO for follow-up of right shoulder pain. X was status post right shoulder scope / repair of X rotator cuff dated X. The pain level was X at the time. X had X. X was working light duty at the desk only. X described mainly stiffness and stated X got a device for X. Examination of the right shoulder revealed X. Strength was X; the biceps were in X. X had full elbow and wrist range of motion (ROM). The plan was to continue X.

Dr. X prescribed X on X.

X attended X on X and X. Per a daily note by X, PT dated X, X reported X was really sore and hurting; X noted X might be doing too much with X. X tolerated the session well at the time. X was X. X noted X was continuing to use the X. X was quite slow in progressing. X continued to have discomfort at X. They discussed modifying X.

An X of the right shoulder dated X showed X.

Treatment to date included X on X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: The requested X, is not medically necessary or supported by the guidelines for this X. The guidelines do not support its use for X. Therefore, X is non-certified."

Per a Letter of Medical Necessity dated X, Dr. X was writing to appeal the denial of continued use of the X for X who was recovering from a X dated X. This was not a

case of X; the correct diagnosis was postoperative shoulder stiffness, which was common after shoulder surgery and significantly impacted function. X started X on X and showed limited improvement after X. At that time, use of the X was approved and began on X and since then, X had made clear, measurable progress. Flexion improved from X degrees to X degrees, abduction improved from X degrees to X degrees, and external rotation improved from X degrees to X degrees. This progress showed that the device was working and removing it at the time risked losing these gains. X was a X and needed full shoulder function to safely return to duty. X, X, and X had all been tried. The X was the only intervention that had moved the needle. Per ODG guidelines, a X was appropriate when there was a X. X met both. X was motivated, complaint, and progressing. Denying another X days could delay X recovery, prolong time off work, or worse, lead to further procedures. Dr. X advised to reconsider and approve an X.

Dr. X prescribed X on X.

Per a reconsideration review adverse determination letter dated X, the request for X was non-certified by X, MD. Rationale: The patient is X on X. The request is for an X. The use of this X. Medical necessity is not established. Therefore, X is 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. The initial request was non-certified noting that, “The requested X, is not medically necessary or supported by the guidelines for this X. The guidelines do not support its use for X, especially X. Therefore, X is non-certified.” The denial was upheld on appeal noting that, “The patient is X on X. The request is for X. The use of this X is not recommended by medical treatment guidelines in the treatment of X. Medical necessity is not established. Therefore, X is non-certified.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. X of the right shoulder revealed X on X followed by X and use of X. X has been diagnosed with adhesive capsulitis of the right shoulder. Guidelines note that the requested X is not recommended for

treatment of X. There are no exceptional factors to support the request outside guidelines. Therefore, medical necessity is not established in accordance with current evidence based guidelines. X is 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