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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X; Amended X; 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 is a X. The diagnoses were bursitis of right shoulder,

superior glenoid labrum from anterior to posterior (SLAP) tear of the right shoulder, unspecified disorder of synovium and tendon of right upper arm, and right rotator cuff tendinitis.

X, MD completed a medical records review / peer review on X regarding X and responded to the specific questions posed to X. With regard to extent of injury questions, “X.” “Please address diagnoses listed on X work status report. The patient's MRI is consistent with X. In my previous review I felt the X was a possible injury but not proven. It does appear that it was previously felt that this was an acute injury by X treating orthopedic surgeon, therefore treating this under the X is causally related and under the ODG per above would be appropriate.” On X, X was seen by X, MD for follow-up on X right shoulder. X was previously seen for X initial visit on X with complaints of right shoulder pain. X is a X. The X shoulder resulting in pain. X had been to the urgent care where an MRI was ordered and X presented to see Dr. X. X went to X for X months without much improvement. X was status X on X. The pain was located on the backside of the right shoulder, top and near underarm and was tender to touch, rated X. It was worsened with lifting and forward raising for long period of time. It was alleviated with X. Focused exam of the right shoulder revealed active motion reduced at X degrees of forward flexion and abduction and XO’Brien’s test; otherwise, normal exam. The assessment was superior glenoid labrum lesion of right shoulder, unspecified disorder of synovium and tendon of right shoulder, and bursitis of right shoulder. The plan was to X. On X, X DPT documented a X plan of care, which was endorsed and agreed upon by Dr. X. X was attending X for X diagnosis of pain in right shoulder (X). Per the PT assessment, X presented to PT with signs and symptoms (s/s) consistent with right shoulder pain secondary to muscular trigger points, rotator cuff dysfunction, and aberrant mechanics, which impacted X ability to perform self-care, ADLs, work, and recreational tasks without difficulty. X would benefit from X. If X failed to make significant progress with X. X was aware of X diagnosis. The plans and goals had been developed and discussed with X; X required X. Per the PT plan, X would be seen X. The treatment plan included X.

An MRI of the right shoulder dated X demonstrated X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD noting “A review for medical necessity and appropriateness of the requested service(s) listed below has been conducted on behalf of X. The requested service(s) or treatment(s) are not medically necessary or appropriate and are therefore not approved.” Rationale: “Per ODG, X is recommended when planned shoulder surgery for X. Per ODG, X is conditionally recommended as a first-line or second-line option. Failure of symptoms to improve after X or more of the following: X. Per ODG, X is recommended for X. In this case, the claimant is in the chronic phase of injury and reports persistent right shoulder pain. While X has been initiated, the claimant has only completed approximately X months of X. There is insufficient documentation detailing X. Per the guidelines, X is conditionally recommended only when there is documented failure of at least X. These criteria have not been fully met in this case. Additionally, imaging does not demonstrate X. Therefore, the medical necessity is not established due to lack of clarity and justification for warranting a surgery. The request for X is not medically necessary.”

Dr. X wrote an appeal letter on X addressed to the Utilization Review Department and noted, “Dear Utilization Review Department, This is a letter of appeal in the decision of denial for the claim of X, claim num X. Your reasoning states that X has not X. I am attaching documents stating that X has actually completed over X. Please see attached clinical notes and X. In regards to the X, Dr. X always list that as a procedure to be done in case after X opens up and evaluates the extent of damage that that does need to be done. Please reconsider your decision for X.”

Per a Reconsideration Review / Notice of Appeal – Approval letter dated X, the appeal request for X was approved by X MD noting, “An appeal review for medical necessity and appropriateness of the requested service(s) listed below has been conducted on behalf of X, The service(s) below under Negotiated Service meets established criteria for medical necessity and reasonableness based on the information provided and is therefore certified (approved).” The Requested Service was “X, and Other Procedures as Indicated (X).” The Negotiated Service was “X” Type of Review / Level was Appeal and recommendation was “Approval” using Screening Criteria “Official Disability Guidelines (ODG) - Treatment In Workers' Comp – Shoulder.” Rationale: “ODG states that X may be indicated for X. Guidelines state that X is recommended for X. Criteria for surgery includes history,

physical examination, and imaging indicate significant shoulder biceps tendon pathology or rupture, X months (X) of X (X) unless combined with X. In this case, the claimant reports X right shoulder pain causing restrictions in activities of daily living. Exam shows X. MRI shows X. The documentation dated X indicates that the claimant has X. Given the ongoing pain causing functional deficits despite the X, the request for X is medically necessary. The request for X is also supported as medically necessary given the persistent pain despite the X, X on exam and imaging evidence of X. The request for X is not supported as review of documented exam and X. The request for X is not specific with regard shoulder pathology or procedures planned. The surgical plan should be clearly documented and with support from imaging and exam. As this is not documented, this part of the surgery request is not supported, Upon discussion, X, X, stated that the X would be fine if the X cannot be approved. X stated that the X was requested since often with these X. X stated that the code will not be used if it is not needed. Therefore, the request is X. The modification of the submitted request was agreed to in discussion."

X – X / Dr. X wrote an email dated X addressed to X regarding "X" and noted, "I have been working this case for about a X now and want to make sure there is nothing else that is needed to approve this case. I originally had mentioned to Utilization review that the X could be omitted thinking that X could bundle the procedures but after conferring with Dr. X , that code needs to X. It is an error on my part. Please reconsider the approval of both codes."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Per ODG, X may be recommended for X. However, there remains a lack of documentation of evidence of X. Therefore, the requested X is not medically necessary and the denial is upheld.

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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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