IRO Express Inc.
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

IRO Express Inc.

Notice of Independent Review Decision

Case Number: X Date of Notice: X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured at work on X when X. The diagnosis was left rotator cuff injury, left shoulder strain, and injury of left middle finger.

On X, X visited X, MD, for left shoulder pain rated X. X was with persistent pain. MRI showed X. Left shoulder examination noted a X. Dr. X noted X was X of the way toward meeting the physical requirements of X job. The assessment was left rotator cuff injury. The plan was to continue X. X wanted to discuss with Dr. X right upper extremity pain on X and follow-up after that. X were recommended. X was to return to work with restrictions and may work the entire shift. The restrictions included no climbing stairs / ladders, no grasping / squeezing, no keyboarding, no lifting more than X pounds; no reaching or overhead reaching more than X hours per day, no lifting / carrying more than X pounds, and must X at work. Restrictions were specific to the left hand / wrist and left arm. An office visit dated X, was documented. The claimant was seen by "X" at X in follow-up by for injury to the left shoulder and left hand middle finger. The assessment was left rotator cuff injury, left shoulder strain, and injury of left middle finger. X was returned to work with restrictions as of X. The restrictions were no climbing stairs / ladders, grasping / squeezing, or keyboarding; maximum X hours reaching and overhead reaching; and no lifting / carrying more than X pounds with the left hand / wrist and left arm. X-rays of the left middle finger were ordered. A Physician Progress Report dated X, by X, MD, noted that X presented with a X. X stated X was doing good with no pain in the finger. X had occasional hypersensitivity in the morning, but it resolved. X-rays of the left middle finger demonstrated that the X. Examination of the left middle finger revealed no X. The assessment was X. X was released from care to follow-up as needed.

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An MRI of the left shoulder dated X, X.

Treatment to date included medications to include X.

Per a utilization review / notice of adverse determination dated X, the request for X was denied by X, MD. Rationale: “ODG by MCG Last review/update date: X. X. Therefore, the request for X is non-certified.”

Per an appeal review and an adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “Per ODG, Sprain shoulder, rotator cuff tear: Medical treatment, sprain: X visits over X weeks. A prior denial indicated that the patient does not meet the criteria for continued treatment. The patient has a diagnosis of a shoulder strain. Previous treatment includes X. The request is for an X. Magnetic resonance imaging (MRI) does X. The patient has already completed the X. There is no reasonable explanation given as to why the patient X. Therefore, the request for X is upheld and non-certified.”

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The ODG supports up to X. In this case, the worker has a left shoulder strain. They have X in the past. There were no exceptional factors noted that would support X. There also was X. As such, X is not medically necessary and determination is recommended upheld.

Upheld

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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