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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X; Amendment 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 Overtuned (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 was involved in a motor vehicle accident. The diagnosis was traumatic incomplete tear of right rotator cuff; strain of muscle, fascia and tendon of long head of biceps, right arm.

On X, X was seen by X, MD for a follow-up of right shoulder. X continued to have issues in the bicipital region and had been having spasm. X had pain with overhead activity and also catching and popping. Physical examination revealed X. Palpation in the bicipital region caused discomfort. Resisted wrist supination revealed X. It was consistent with a X. Range of motion of right shoulder revealed forward elevation to X degrees, external rotation to X degrees, and, internal rotation to the X level. Discomfort was noted with internal rotation. X exhibited decreased X. A significantly X impingement sign, X cross arm adduction test. Tenderness was noted over the X. Internal and external rotation of the arm at the side revealed X. Hawkins test was X. That was reproducible. It was consistent with X. Rotator cuff strength testing in both forward elevation, abduction, and external rotation showed X. It was consistent with a X. A X was also noted with testing. A X was noted with abduction strength testing. X was not able to have an MRI scan secondary to a X. An MRI scan was X. As X already had X. X would be contraindicated which would X. X was extremely active and had a X. X did not X. Furthermore X was having significantly increasing symptoms in the X. X had been treated with X. Unfortunately X had not been able to progress with X activity. It had been almost X months since X injury. Further X would not be a judicious utilization of resources. At this time the recommendation was that of an independent review organization evaluation. X visited Dr. X on X for right shoulder follow-up. X was denied again. X continued to have issues in the X. X also continued to X. X also had pain which X. X was having X. X endorsed pain with overhead activity and X. X had undergone all methods of X. Inspection of the arm again revealed X. Resisted flexion of the elbow today did reveal X. Palpation in the X caused discomfort. X revealed X. It was consistent with a X. It was reproducible. Examination of the shoulder revealed forward elevation to X degrees, external rotation to X degrees, and internal rotation to the X level. X was noted with X. A significantly X impingement sign, Xcross arm adduction test. Tenderness was noted over the X. Internal and external rotation of the arm at the side revealed X. Hawkins test was X. It was consistent with X. It was reproducible. Rotator cuff strength testing in both forward elevation, abduction, and external rotation showed X. X was noted. It was consistent with a X. A X was also noted with testing. Again, the plan was for X. X had been treated with X. Unfortunately was not able to progress with X activity. It was noted that it had now been almost X months since X injury and further X would not be a judicious utilization of resources. Independent review organization determination was recommended

due to repeated denials. A CT scan of the right shoulder dated X revealed X. If clinically warranted, an X was recommended. There was X. X was noted. Treatment to date included 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 appropriate. The X records have been submitted for review. However, the imaging report does not support the X request. There is X. Furthermore, there is X, Thus, the imaging report does not support the X request. Medical necessity cannot be established. Therefore, X is not medically necessary. "Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "In this case, given the documented X is supported. Given the documented X is supported. However, there X. Additionally, while there are X on exam, imaging X. As such, partial certification is recommended with certification for APPEAL: X. However, there was no successful peer discussion to discuss the modification, the request cannot be modified as this is required in X. Therefore, the request is recommended upheld."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
I have reviewed the records submitted, along with additional records submitted on X. In this case, X would be supported as medically necessary as the conditions X. However, there X. Additionally, while there are X on exam, imaging X. There was X which is a requirement for X. Therefore, the request cannot be partially certified. The request for X is recommended upheld and not medically necessary.

Upheld

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **AHRQ- AGENCY FOR HEALTHCARE RESEARCH & 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**
- ☐ **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)**