

True Resolutions Inc.

An Independent Review Organization

1301 E. Debbie Ln. Ste. 102 #624

Mansfield, TX 76063

Phone: (512) 501-3856

Fax: (888) 415-9586

Email: manager@trueresolutionsiro.com

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX shoulder joint injection under fluoroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|--------------------------------|
| <input type="checkbox"/> Overturned | Disagree |
| <input type="checkbox"/> Partially Overturned | Agree in part/Disagree in part |
| <input checked="" type="checkbox"/> Upheld | Agree |

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a now XXXX with a history of occupational claim from XXXX. The mechanism of injury was detailed as XXXX. The current diagnoses were documented as strain of muscles and tendons of rotator cuff of XX shoulder initial encounter. A XX MRI shoulder without contrast dated XXXX, impressions were listed as mild distal XX tendinitis. The long biceps tendon was poorly evaluated on this study. Mild to moderate XX osteoarthritis and mild XX down sloping of the XX was seen. XX outlet shows no significant narrowing. Per consultation dated XXXX, the patient complained of XX shoulder pain. The patient did not have physical therapy or an injection at this point. A physical examination of the patient's XX shoulder revealed range of motion for abduction was normal. The patient's hand was placed behind their back was approximately 50% normal as well. There was some tenderness in the XX shoulder. Motor strength was grossly intact for the patient. Per workers non-network reconsideration adverse determination dated XXXX, the patient's complaint was continued XX shoulder pain. The patient reach behind was 50% of normal. There was point tenderness, motor strength intact and an abnormal abduction listed for the patient. The treatment plan included a XX shoulder joint injection under fluoroscopy.

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

Regarding the request for a XX shoulder joint injection under fluoroscopy, Official Disability Guidelines recommends XX XX for short-term use only. Mild to moderate XX osteoarthritis and mild XX down sloping of the XX was seen. XX outlet shows no significant narrowing. A physical examination of the patient's XX shoulder revealed range of motion for abduction was normal. The patient's hand was placed behind their back was approximately 50% normal as well. There was some tenderness in the XX shoulder. Motor strength was grossly intact for the patient. No information was submitted to show the patient's pain was not controlled adequately by recommended conservative treatments (physical therapy and exercise, non-steroidal anti-inflammatory drugs or acetaminophen). The imaging show no significant narrowing and significant findings.

As such, the request for a XX shoulder joint injection under fluoroscopy is not medically necessary. The previous decision is upheld.

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

MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Shoulder Chapter/ XX XX