Pure Resolutions LLC

Notice of Independent Review Decision

Case Number: XX Date of Notice: 4/4/2019

Pure Resolutions LLC

An Independent Review Organization
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IRO REVIEWER REPORT

Date: 4/4/2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI of XX

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

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

PATIENT CLINICAL HISTORY [SUMMARY]: XX. XX XX is a XX-year-old XX who was injured on XX. XX was XX XX by two XX of XX XX XX when XX working in XX and XX a XX XX. XX coworkers were on the XX XX and XX. XX was working on the XX XX when the XX XX XX XX and XX on XX XX XX. XX was diagnosed with pain in the XX XX and XX XX. On XX, XX performed XX XX arthroscopy with debridement, XX decompression, XX XX XX, arthroscopic XX XX, and arthroscopic XX XX repair. The postoperative diagnoses were XX XX full-thickness XX XX, partial XX tendon tear, partial XX tear, and XX joint XX. An MRI of the XX XX done on XX demonstrated status post prior XX XX repair, with XX and XX partial tearing of the distal XX and adjacent XX XX, but there was no recurrent full-thickness XX XX tear identified or tendon retraction, tendinopathy of the XX XX tendon without tear, mild XX / XX XX, status post prior XX and XX joint decompression, status post prior XX XX, and minimal XX XX of the XX joint. XX. XX evaluated XX. XX on XX. XX was status post XX surgery. XX noted consistent XX / XX pain and numbness that radiated into XX XX. The pain occurred with activity on the XX and anterior side. XX. XX continued to have limited improvement and worsening of full-thickness tear. XX XX examination showed a decreased range of motion.

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The strength testing was limited secondary to pain. The assessment was XX and sprain of the sprain of XX XX XX. XX ordered an MRI of the XX XX and XX XX. The treatment to date consisted of pain medications, surgical intervention and XX sessions of postoperative XX therapy (lack of progress) for the XX XX.

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 MRI of XX XX is not recommended as medically necessary. There is no current, detailed physical examination submitted for review. There are no radiographic reports of the XX XX submitted for review. There is no comprehensive assessment of treatment for the XX XX completed to date or the patient's response thereto submitted for review.

Therefore, medical necessity is not established in accordance with current evidence based guidelines and the decision is 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

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW XX PAIN

☐ INTERQUAL CRITERIA

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

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL