Clear Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 CR
Austin, TX 78731
Phone: (512) 879-6370
Fax: (512) 572-0836
Email: @cri-iro.com

Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT
Date:X Amendment 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 sustained an injury on X. X . The diagnoses included biceps tendinitis of right shoulder, right shoulder impingement syndrome, and non-traumatic partial right rotator cuff tear. X was seen by X, DO on X for a follow-up of X. X noted some improvement in pain with X. Right shoulder examination revealed X. It was noted that X noted X. X was unable to adequately rehab the shoulder due to the exercises causing excruciating pain. X had been completing X. X had attempted X. X also noted X. On X, X reported continued pain in right shoulder. Physical examination was unchanged from the prior visit. X had X. X noted X had X. They discussed the risks and benefits of X. X had exhausted X. X previously had X. X had elected to proceed with X, which was denied by WC insurance. X-rays of the right shoulder on X showed X. An MRI of the right shoulder on X showed X. Treatment to date included X. Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: "In this case, claimant has X. X has been treated with X. However, the formal MRI report was not provided. Therefore, X is not medically necessary. "Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: "The MRI in this case show no pathology to support the requested procedure. There is only a X. Therefore, X, is not medically necessary. The requested X is not medically necessary. The requested procedure is not supported by the imaging findings. No new information has been submitted which would overturn the previous denials. X is not medically necessary and non certified

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

The requested X is not medically necessary. The requested procedure is not supported by the imaging findings. No new information has been submitted which would overturn the previous denials. X is not medically necessary and non certified
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)**