

I-Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 IR
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 790-2280
Email: @i-resolutions.com

Notice of Independent Review Decision
Amendment X

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 Overturned Agree in part/Disagree in part
- Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD, as not medically necessary. Rationale: "ODG recommends lack of improvement with X. The provider is requesting authorization for X. The patient's MRI of the right shoulder on X demonstrated X. The patient has had X sessions of X. It was noted that the patient has X. The patient is also noted to X. Dr. X is requesting X, however there were no consultation notes from Dr. X submitted for review. ODG recommends lack of improvement with X. It appears that the patient has had X. Additionally, the patient appears to have X. There is no indication that this has been ruled out as a source of the patient's symptoms. Therefore, my recommendation is to NON-CERTIFY the request for X:X. Therefore, my recommendation is to NON-CERTIFY the request for X was denied by X, MD. Rationale: "Treatment has included X sessions of X, no X. The clinical basis for denying these services or treatment: Official Disability Guidelines state that there should be X. Although there is shoulder pain in this case, there has been minimal X. Prior peer reviews non-certified. This remains relevant. The patient completed X sessions of X, but other conservative measures should be exhausted to include X is considered. Moreover. the most recent report is from Dr. X from X. There are no recent reports from Dr.X, the requesting surgeon, indicating current clinical findings. This should be confirmed. No additional clinical information is available to overturn the prior denial. Therefore, my recommendation is to NON-CERTIFY the request for APPEAL X. The clinical basis for denying these services or treatment: Official Disability Guidelines state that there should be lack of improvement with X. Prior peer reviews non-certified X. This remains relevant. The patient completed X sessions of X, but other X. ODG guidelines recommend a positive response to a X. Moreover, the most recent report is from Dr. X from X. There are no recent reports from Dr. X, the requesting surgeon, indicating current clinical findings. This should be confirmed. No additional clinical information is available to overturn the prior denial. Therefore, my recommendation is to NON-CERTIFY the request for APPEAL X." "Treatment has included X sessions of X, no X. The clinical basis for denying these services or treatment: Official Disability

Guidelines state that there should be lack of X. Although there is shoulder pain in this case, there has been X. Prior peer reviews non-certified right shoulder arthroscopy, as there was no indication of an X. This remains relevant. The patient completed X sessions of X but other conservative measures should be exhausted to include X is considered, Moreover, the most recent report is from Dr, X from X. There are no recent reports from Dr.X, the requesting surgeon, indicating current clinical findings. This should be confirmed. No additional clinical information is available to overturn the prior denial. Therefore, my recommendation is to NON-CERTIFY the request for APPEAL X.” “The patient has had only minimal conservative treatment to date that included just X sessions of X. The clinical basis for denying these services or treatment: ODG recommends biceps tenodesis after X months (X months for isolated X)X. Although there is shoulder pain in this case, there has been X. Prior peer reviews non-certified X. This remains relevant. The patient completed X sessions of X, but other conservative measures should be exhausted to include X is considered. Moreover, the most recent report is from Dr. X from X. There are no recent reports from Dr.X, the requesting surgeon, indicating current clinical findings. This should be confirmed. No additional clinical information is available to overturn the prior denial. Therefore, my recommendation is to NON-CERTIFY the request for APPEAL X.” “The patient has not been found to be a candidate for surgery. The clinical basis for denying these services or treatment: ODG guidelines recommend X. X has not been found to be medically appropriate. As such, there is no medical support for post-operative orthosis. Therefore, my recommendation is to NON-CERTIFY the request for APPEAL X.” The requested surgical procedure is not medically necessary. The submitted medical records do not demonstrate that the patient has attempted appropriate conservative treatment for at least X months in duration. No new information has been provided from the treating provider 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 submitted medical records do not demonstrate that the patient has attempted appropriate X. No new information has been provided from the treating provider 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)