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Notice of Independent Review Decision

SENT TO: Texas Department of Insurance
Managed Care Quality Assurance Office
(MCQA) MC 103-5A Via E-mail
IRODecisions@tdi.texas.gov

DATE NOTICE SENT TO ALL PARTIES: 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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a X who sustained an industrial injury on X and is X. A review of the medical records indicates that the injured worker is undergoing treatment for X.

Prior diagnostic testing included X.

An MRI of the left shoulder dated X has X. X-rays of the left shoulder dated X have X. Previous treatment has included X. Previous surgeries included X.

Initial X evaluation dated X has the injured worker with left shoulder, left elbow, and left knee pain. The pain is rated at X. The pain remains mainly in X left shoulder, and X cannot X. The left shoulder exam reveals X. Active forward elevation is X, abduction X, and abduction internal rotation X. Strength is extremely weak for X. X are X. X has X. The treatment plan included an X.

A progress report dated X has the injured worker with left shoulder pain for X months. The pain is to the lateral side of the left shoulder and is described as X. The pain is X. The pain is rated at X. The left shoulder exam reveals X. X has active forward elevation to X, abduction to X, and internal rotation to X. X is extremely weak for X. X are X. X has X. X-rays are noted to demonstrate X. The treatment plan included an X.

The Adverse determination notice dated X was for the X. The rationale stated, although surgery is supported, the

request for X is non-certified. As such, a partial recommendation could not be rendered. The manipulation is not certified as there is no documentation of X. The reconsideration request dated X was also non-certified. The rationale states the concurrent request for X would not be supported at the same time of the X. Therefore, the request is non-certified.

The letter of medical necessity dated X is an appeal for the "X. X has undergone extensive pre-operative education and understands all the risks, benefits, and possible complications.

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

In this case, this X sustained an industrial injury on X, is seeking authorization for a X, and is undergoing treatment for chronic left shoulder pain.

Overall, X presented on X with left shoulder pain for X months. The pain is to the lateral side of the left shoulder and is described as X. The pain is X. The pain is rated at X. The left shoulder exam reveals X. X has active forward elevation to X, abduction to X, and internal rotation to X. X is extremely weak for X. X are X. X has X.

X: As per ODG, “

**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 BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL
EXPERIENCE AND EXPERTISE IN ACCORDANCE
WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE
GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES &
TREATMENT GUIDELINES**
- PRESSLEY 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)**