CPC Solutions
An Independent Review Organization
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Notice of Independent Review Decision

***Amended Date:* X**

Review Outcome:
A description of the qualifications for each physician or other health care provider who reviewed the decision:
X

Description of the service or services in dispute:

X.

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)

The claimant is a X who sustained an injury on X when X sustained a X. The claimant was subsequently diagnosed with adhesive capsulitis and joint heterotopic ossification. The records noted use of X. While the claimant was reported to have attended X. No formal imaging reports for the left shoulder were included for review. The X clinical report noted limited left shoulder range of motion with forward flexion to X degrees and abduction to X degrees. There was a firm endpoint with external rotation.

The left shoulder open release with removal of heterotopic ossification being requested was denied by utilization review which noted lack of imaging studies or documented failure of non-operative measures to support the surgical request.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

In this case, the claimant presents with ongoing issues regarding left shoulder range of motion. The current physical exam did note X. However, passive vs. active range of motion measurements were not detailed in the exam. It is unclear whether the diagnosis of adhesive capsulitis or joint heterotopic ossification is the primary contributing factor for the current range of motion issues. Further, the records available for review did not detail X. No X records were included for review. Further, a current formal imaging report for the left shoulder was not included for review determining the potential source of the claimant's current range of motion issues. Therefore, in this reviewer's opinion medical necessity is not established for the proposed surgical procedures and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase

☐ AHRQ-Agency for Healthcare Research and Quality Guidelines

☐ DWC-Division of Workers Compensation Policies and Guidelines

☐ European Guidelines for Management of Chronic Low Back Pain

☐ Internal 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 and Treatment Guidelines

☐ Pressley Reed, the Medical Disability Advisor

☐ Texas Guidelines for Chiropractic Quality Assurance and 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)