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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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 on X. X stated that X was X. X stated that X somehow took a wrong step and fell, and hit the wall injuring X head, left shoulder, and left arm. X stated at that time X wearing flat foot wear. X denied dizziness. X reported a limited range of motion in the left shoulder and noticed a bruise at the left elbow. X also developed neck and lower back pain after the injury. The diagnosis was unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic (M75.102).

X was seen by X, MD on X for complaints of the left shoulder. X presented for X. X had been engaging in X. X reported a slow recovery and limited range of motion of the affected shoulder. X noted the pain when extending the arm, especially activities such as making bed. On examination of the left shoulder, active range of motion showed forward flexion to X degrees, abduction to X degrees, external rotation to X degrees, and internal rotation sufficient to reach the posterior superior iliac spine with reported pain. Passive range of motion showed forward flexion to X degrees and external rotation to X degrees. X reported significant pain during certain movements, particularly when extending the arm as if to make a bed and described feeling like the arm might break. X noted persistent pain at night, localized through the arm. X had roughly X of anticipated healing. The assessment included tear of left rotator cuff, unspecified tear extent, unspecified whether traumatic. A referral for X was provided for the left shoulder, X. X was medically necessary to address impairment / functional loss and to expedite return to full activity.

X attended a X by X, PT on X for complaints of the left shoulder. X reported overall improvement, but still painful and weak. On examination

of the left shoulder, active range of motion showed X degrees of flexion and X degrees of abduction. The impairment list consisted of active range of motion, pain, and muscle performance. The assessment included left shoulder fracture, left shoulder strain, and tear of left rotator cuff, unspecified tear extent, unspecified whether traumatic. Per assessment, X overall progress was slower than expected. X did have improved flexion, active range of motion, but the abduction was little regressed. Overall, X noted improvement in regards to exercise tolerance and pain. treatment plan was to X.

X presented to see X, DO on X for a follow-up of left shoulder symptoms. X was waiting for surgery and had been working modified duty. X reported sustaining a head injury at work. At that time, the symptoms consisted of dull local pain. Associated symptoms included headaches. X probably experienced loss of consciousness. X had a direct impact on X head with the wall. X also noted left arm pain and upper neck pain. On examination of the left shoulder, appearance was X. The range of motion was very limited in X. X was unable to do any flexion or abduction over X degrees. Pain with movement was noted. Muscle strength was X. X was approximately X of the way toward meeting the physical requirements of X job. The assessment included shoulder fracture, left, closed, initial encounter; and tear of left rotator cuff, unspecified tear extent, unspecified whether traumatic. X had been waiting for X to be approved, ordered by a specialist.

An MRI of the left shoulder dated X showed X. X was noted. There was comminuted, nondisplaced X. The study showed X. X was noted. X-rays of the left shoulder dated X showed X. There was X. The study was X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "In this case, the patient has been diagnosed with unspecified rotator cuff tear / rupture of left shoulder; and left shoulder pain. The patient reports subjective complaints of left shoulder pain. Physical examination revealed active range of motion of forward flexion to approximately X degrees, abduction to approximately X degrees, external rotation to approximately X degrees, and internal rotation sufficient to reach the posterior superior iliac spine with pain; passive range of motion forward flexion to approximately X degrees, external rotation to approximately X degrees; and significant pain during certain movements, particularly with extending the arm. There is documentation the patient has X. X is excessive in nature. The patient can transition to a X. Therefore, medical necessity has not been established. As such, the request X is noncertified".

Per a reconsideration review letter dated X, the prior denial was upheld by X, MD. Rationale: "As of X, the patient has X. The patient saw the treating provider on X. The patient reports left shoulder pain. On examination, active forward flexion is X degrees, and passive is X degrees. External rotation is X degrees actively and X degrees passively. Internal rotation is to the posterior superior iliac spine. The patient was diagnosed with a tear in the left rotator cuff. The requested X is not medically necessary. The patient has X. X is not supported by the guidelines. Therefore, the request for appeal (amendment) X is upheld and noncertified."

The request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "In this case, the patient has been diagnosed with unspecified rotator cuff tear / rupture of left shoulder; and left shoulder pain. The

patient reports subjective complaints of left shoulder pain. Physical examination revealed active range of motion of forward flexion to approximately X degrees, abduction to approximately X degrees, external rotation to approximately X degrees, and internal rotation sufficient to reach the posterior superior iliac spine with pain; passive range of motion forward flexion to approximately X degrees, external rotation to approximately X degrees; and significant pain during certain movements, particularly with extending the arm. There is documentation the patient has X. X is excessive in nature. The patient can transition to a X. Therefore, medical necessity has not been established. As such, the request for X is noncertified". Per a reconsideration review letter dated X, the prior denial was upheld by X, MD. Rationale: "As of X, the patient has X. The patient saw the treating provider on X. The patient reports left shoulder pain. On examination, active forward flexion is X degrees, and passive is X degrees. External rotation is X degrees actively and X degrees passively. Internal rotation is to the X. The patient was diagnosed with a tear in the left rotator cuff. The requested X is not medically necessary. The patient has already X. X is not supported by the guidelines. Therefore, the request for X is upheld and noncertified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient has X. The request for X. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The patient has X. 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 request for X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review adverse

determination letter dated X, the request X was denied by X, MD. Rationale: "In this case, the patient has been diagnosed with unspecified rotator cuff tear / rupture of left shoulder; and left shoulder pain. The patient reports subjective complaints of left shoulder pain. Physical examination revealed active range of motion of forward flexion to approximately X degrees, abduction to approximately 80 degrees, external rotation to approximately X degrees, and internal rotation sufficient to reach the posterior superior iliac spine with pain; passive range of motion forward flexion to approximately X degrees, external rotation to approximately X degrees; and significant pain during certain movements, particularly with extending the arm. There is documentation the patient has attended X. X is excessive in nature. The patient can transition to a X. Therefore, medical necessity has not been established. As such, the request for X is noncertified". Per a reconsideration review letter dated X, the prior denial was upheld by X, MD. Rationale: "As of X, the patient has X. The patient saw the treating provider on X. The patient reports left shoulder pain. On examination, active forward flexion is X degrees, and passive is X degrees. External rotation is X degrees actively and X degrees passively. Internal rotation is to the posterior superior iliac spine. The patient was diagnosed with a tear in the left rotator cuff. The requested X is not medically necessary. The patient has already X. X is not supported by the guidelines. Therefore, the request for appeal (amendment) X is upheld and noncertified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient has X. The request for X would exceed guidelines. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The patient has completed X. 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:

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE