

Pure Resolutions LLC
An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 779-3288
Fax: (888) 511-3176
Email: @pureresolutions.com

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 is a X who was injured at work on X. While at work, X slipped and grabbed an arm rail with X arm and caught X. X felt a pop. Since then, X had shoulder pain with overhead activity. The diagnoses were superior glenoid labrum lesion of right shoulder, initial encounter and sprain of right shoulder.

On X, X was seen by X, MD, for follow-up for sprain of right shoulder. X had injury at work on X. X presented with the chief complaint of X. X had been seen last in X and X was denied by Workers' Compensation. Since then, in the past X months, X had gone to X and noted continued symptoms with active use of the right shoulder and pain. X was being referred back to their office for reevaluation. On examination, weight was 209 pounds, body mass index (BMI) was 29.15 kg/m² and blood pressure was 148/92 mmHg. X rated pain as X. Right shoulder examination revealed X had X. X had some discomfort above X head. X had X. There was X. X had some discomfort with X. X had pain to testing X was noted. X was stable to X. There was some generalized shoulder tenderness present. The MRI of the right shoulder showed X. Biceps appeared X. X to the X was noted. X was appeared X. X were noted. It was noted that the right shoulder showed X. X had X. X continued to complain of pain with active use of the right shoulder. X had been in X the last eight (X) weeks. Treatment plan was to proceed with X. They would seek for Workers' Compensation approval for X.

An MRI of right shoulder dated X showed X. X was noted. No X was noted. X were noted.

Treatment to date included X.

Per a utilization review adverse determination letter / peer review report dated X by X, MD, the request for X was denied. Rationale: "ODG by MCG Last review/update date: X. Evidence Summary Orthopaedic surgeons can usually determine correct diagnoses through physical examination and imaging studies alone. X." The requested surgical procedure is not medically necessary. The submitted imaging report does not clearly define the presence of X. Further diagnostic workup was suggested with an MR arthrogram. The patient has completed X. X has not been established. As such, the guidelines have not been met. Therefore, the request for X medically necessary: X is non-certified."

Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Per ODG by MCG, X Last review/update date: X, "Conditionally Recommended Recommended with indications". Per ODG by MCG, X, "Recommended X are documented." In this case, there is no documentation of exhausted X. Further, an MR arthrogram was recommended for the X. Absent this information, the request is noncertified."

The submitted request is X. The right shoulder MRI report did note X. This was a X. X can be addressed through surgery. The claimant has not improved with X. While there may be indications to proceed with a X is not supported and it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld. 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 submitted request is X. The right shoulder MRI report did note X. This was a X. X can be addressed through surgery. The claimant has not improved X. While there may be indications to proceed with a X is not supported and it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld. 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