

CPC Solutions

An Independent Review Organization

P. O. Box 121144 Phone Number:
Arlington, TX 76012(855) 360-1445
Email: @irosolutions.com

Fax Number:
(817) 385-9607

Notice of Independent Review Decision

Amended Date: X

Case Number: X

Date of Notice: 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 while X. The claimant had been followed for a history of X. The claimant attended X in X. The X right shoulder MRI report noted X. There was X. The X evaluation noted difficulty with right shoulder range of motion. The claimant had a few prior surgeries. The physical exam noted X. There was X.

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

The proposed surgical interventions for the X. Upon review of the clinical findings, the claimant's current exam is most consistent with adhesive capsulitis, given the MRI report did note evidence of capsulitis. The current exam did not detail evidence of ongoing right shoulder impingement. The MRI report did not detail any significant tearing of the X that would support proceeding with surgical repair as requested. Therefore, it is this reviewer's opinion that medical necessity for the surgical requests to include X is not established 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)