

Pure Resolutions LLC
Notice of Independent Review Decision
Pure Resolutions LLC
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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:

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- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X with an injury date of X. X sustained an injury after X. The assessment included strain of muscle and / or tendon of elbow region and synovitis of elbow.

X was seen by X, MD on X for a follow-up of right elbow pain secondary to work-related injury. The discomfort was mild to moderate in intensity and had been progressively worsening. The quality of pain was described as dull and aching. Associated symptoms consisted of discomfort with repetitive use. An MRI dated X showed osteoarthritis in the right elbow. There was mild tendinopathy over triceps tendon. The partial tearing of the common extensor tendon was noted. On examination of the right elbow, there was mild discomfort posterolaterally within the soft spot. Range of motion showed active flexion of more than X degrees without discomfort. Active extension was full of painless arch of motion. Active supination and pronation were X degrees without discomfort. The strength was X with flexion and extension, pronation, and supination. Tinel's sign was X. Dr. X thought that X had early osteoarthritis in the right elbow as noted on MRI. X had simply exacerbated the chondromalacia with the work activity. A X was recommended as it had been X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request of X is denied by X, MD. Rationale: "Based on the documentation provided, the treating physician is requesting a X. The claimant was diagnosed with Strain of muscle and / or tendon of elbow region and Synovitis of elbow. Per ODG, X are not recommended for Tendinopathy / tendonitis / bursitis; Arthritis; Epicondylitis (lateral, medial); and Ulnar neuropathy. In this case, the injury occurred over X months ago. The claimant was previously approved for a X. The office note dated X reported the claimant has some early osteoarthritis in the right elbow as noted on MRI. It was noted the claimant exacerbated the chondromalacia with X work activity and was recommended for X. While the X previously provided relief, the

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ODG guidelines and recent evidence suggest that X should be used cautiously, particularly with conditions like early osteoarthritis and chondromalacia, as repeated use can potentially worsen joint degeneration. Therefore, medical necessity has not been established.”

Per a reconsideration review adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: “ODG by MCG Last review/update date: X. The requested X is not medically necessary. The guidelines do not support X. In addition, the percentage of relief was not provided. As such, the guidelines have not been met. Therefore, the requested X is non-authorized.”

Based on the clinical information provided, 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 of X is denied by X, MD.

Rationale: “Based on the documentation provided, the treating physician is requesting a X. The claimant was diagnosed with Strain of muscle and / or tendon of elbow region and Synovitis of elbow. Per ODG, X are not recommended for X. In this case, the injury occurred over X months ago. The claimant was previously X. The office note dated X reported the claimant has some early osteoarthritis in the right elbow as noted on MRI. It was noted the claimant exacerbated the chondromalacia with X work activity and was recommended for X as it has been X months since the X, and it did give the claimant good long-term relief. While the X previously provided relief, the ODG guidelines and recent evidence suggest that X should be used cautiously, particularly with conditions like early osteoarthritis and chondromalacia, as repeated use can potentially worsen joint degeneration. Therefore, medical necessity has not been established.” Per a reconsideration review adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: “ODG by MCG Last review/update date: X, X for Elbow Conditions Treatment type: X Not Recommended (generally)-NR Not recommended as a routine intervention for epicondylitis or ulnar neuropathy, based on newer quality evidence. The requested X is not medically necessary. The guidelines do not support X. In addition, the percentage of relief was not provided. As such, the guidelines have not been met. Therefore, the requested X is non-authorized.” There is insufficient information to support a change in determination, and the

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previous non-certifications are upheld. The Official Disability Guidelines note that X are not recommended as a routine intervention for X, based on newer quality evidence. There is also little specific evidence to support X. When approval occasionally occurs for individual patients beyond these guidelines, then only a one-time injection using lower X. There are no exceptional factors to support the request outside guideline recommendations. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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:

Based on the clinical information provided, 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 of X is denied by X, MD. Rationale: "Based on the documentation provided, the treating physician is requesting a X. The claimant was diagnosed with Strain of muscle and / or tendon of elbow region and Synovitis of elbow. Per ODG, X are not recommended for Tendinopathy / tendonitis / bursitis; Arthritis; Epicondylitis (lateral, medial); and Ulnar neuropathy. In this case, the injury occurred over X months ago. The claimant was previously approved for a X. The office note dated X reported the claimant has some early osteoarthritis in the right elbow as noted on MRI. It was noted the claimant exacerbated the chondromalacia with X work activity and was recommended for X as it has been X months since the X, and it did give the claimant good long-term relief. While the X previously provided relief, the ODG guidelines and recent evidence suggest that X should be used cautiously, particularly with conditions like early osteoarthritis and chondromalacia, as repeated use can potentially worsen joint degeneration. Therefore, medical necessity has not been established." Per a reconsideration review adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: "ODG by MCG Last review/update date: X, X Not Recommended (generally)-NR Not recommended as a routine intervention X. The requested X is not medically necessary. The guidelines do not support X. In addition, the percentage of relief was not provided. As such, the guidelines have not been met. Therefore, the

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requested X is non-authorized.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines note that X are not recommended as a routine intervention for X. There is also little specific evidence to support X. When approval occasionally occurs for individual patients beyond these guidelines, then only a X. There are no exceptional factors to support the request outside guideline recommendations. Therefore, medical necessity is not established in accordance with current evidence based guidelines. X is not medically necessary and non-certified

Non-Certified

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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