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An Independent Review Organization
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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 at work on X. The mechanism of injury was not documented. The diagnosis was left shoulder pain, unspecified chronicity.

On X, X was seen by X, MD, for evaluation of chief complaint of left shoulder pain. That day, X presented for evaluation of MRI results of left shoulder. X was X. Pain score was X, could get to a X with certain movement. X was administered on X with relief for a couple of days. On examination, weight was 230 pounds and body mass index (BMI) was 33.96 kg/m². Left shoulder examination revealed X. X has full passive range of motion of the shoulder. X was distally neurovascular intact. There were X. Dr. X assessed that, at the time, X was doing well with X pain, had been under control and X was performing X. X was still having intermittent pain throughout the shoulder. Dr. X would like to continue with the X and recommended at least X more visits to aid X in X range of motion and strength. X was written for this prescription. Given ongoing pain, Dr. X also elected to proceed forward with a X on the day which X tolerated well. Dr. X reviewed X new MRI which X. X rotator cuff tendon was intact. On X, X was evaluated by X, PT, for chief complaint of left shoulder pain. X was X. X had been doing exercises at home but continued to have significant weakness and pain in the shoulder. X had X on X left shoulder on X with little improvement. X had difficulty with sleeping at night, reaching forward, lifting arm to the side, and reaching behind X back. X would like to continue with X to help X get back to full potential. X rated the ongoing pain as X, pain at best was X and at worst was X. Left shoulder examination revealed X. The active range of motion showed forward flexion was X, adduction was X, external rotation at X degrees of abduction was X and internal rotation at X degrees of abduction was to X. Passive range of motion at forward flexion was X, abduction was X, external rotation at X degrees was X and internal rotation at X degrees was X. Pain was noted with all range of motion. Tenderness was present globally, at the anterior and posterior shoulder. The strength was X at elevation,

abduction, external and internal rotation at side. X was hypomobile with inferior GH glides. It was noted that X had demonstrated improvements in range of motion since prior evaluation, however, the pain and weakness were X most notable deficits in the left shoulder. X would benefit from X to address pain and weakness in the shoulder to return to normal functional without pain. X was recommended for X.

An MRI of the left shoulder dated X revealed changes X. Moderate grade X was noted. Moderate to X was noted. Status X was noted. X was present. Mild superior X was seen. X with moderate X was noted. Status X was seen.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The Official Disability Guidelines recommend up to X. The guidelines suggest that X may be indicated when functional progress has been made during initial therapy, maximum improvement has not yet been attained, and the claimant is actively participating and is adherent to plan of care. In this case, the claimant has a history of X. They continue to report left shoulder pain, weakness and functional limitations despite exercises at home and a X. They had limited range of motion with pain, tenderness, decreased strength, and hypomobility. It is noted in the records that the claimant has demonstrated improvements in range of motion since last evaluation. However, although improvements in mobility were noted, the specific number of completed X was not provided in the submitted records. In addition, considering that their last X. As such, the request for X is noncertified."

Per a reconsideration review adverse determination letter dated X by X, DO, the appeal request for X was denied. Rationale: "The Official Disability Guidelines recommend X. X may be indicated when there is functional progress made during initial therapy and maximum improvement has not yet been attained. Based on the records, the claimant suffers from continued left shoulder pain that was rated at X after having X. On the exam, there was a noted decreased range of motion, tenderness at the anterior and posterior shoulder, X strength, and hypomobile mobility with inferior glenohumeral glides. The claimant has been attending X postoperatively with some progress with range of motion, but the claimant continues to have limitations with reaching, object retrieval, push and pull,

carrying, and participation with daily activity tasks. Because of this, the provider is requesting more X. While X is needed to help improve functionality and reduce pain, the request is not supported as the total number of visits the claimant had were not specified. This information is necessary to determine if the requested X. Also, although it was mentioned that the claimant has progress with the range of motion, the detailed objective functional gains from prior treatments were not documented to justify the necessity of X. Therefore, the request for X is noncertified.”

Based on the submitted medical records and although improvements in mobility were noted, the specific number of completed X was not provided in the submitted records. In addition, considering that their last X, there is lack of justification provided or extenuating circumstances on why the claimant had prolonged treatment with X. Thus, X is not justified or supported by the guidelines and the medical literature. No new information has been provided to support the request and overturn the previous denials. Thus, medical necessity has not been established. 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 submitted medical records and although improvements in mobility were noted, the specific number of completed X was not provided in the submitted records. In addition, considering that X. Thus, X is not justified or supported by the guidelines and the medical literature. No new information has been provided to support the request and overturn the previous denials. Thus, medical necessity has not been established. 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