

**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 who was injured on X. X stated X was X. The diagnosis was left shoulder pain (X); and traumatic rupture of left pectoralis major tendon (X).

On X, X was evaluated by X MD, for left shoulder / biceps pain. X stated on X, X was X. X states a couple of days later, X had bruising and swelling to X biceps. X had pain with pushing and pulling. X was seen at X where x-rays were taken, and an MRI was ordered. X was referred to Dr. X for further evaluation. On examination, the left pectoralis revealed X. Per the note, an MRI of the left humerus revealed X. The proximal biceps tendon was X. If clinically indicated, X protocol MRI could be obtained. The age of injury was acute. X-rays of the left shoulder were reviewed and revealed X. No fracture was X. The diagnosis was left shoulder pain (X); and traumatic rupture of left pectoralis major tendon (X). Dr. X assessed a X.

X-rays of the left shoulder dated X, were unremarkable. Review of an MRI of the left humerus dated X, revealed X. The proximal biceps tendon was X. If clinically indicated, X protocol MRI could be obtained. The age of injury was acute.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "Full certification is not supported as the requests in their entirety do not meet guidelines. ODG states that X is not recommended for the treatment of X. In this case, evidence-based guidelines do not recommend X. Exceptional factors to support this request outside of guideline recommendation have not been identified. Therefore, this request is not medically necessary."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "Certification is not supported as the request does not meet guidelines. ODG notes that X is not recommended for X. In this case, as per the recent guidelines X is not recommended for X. There are no exceptional factors identified to support this procedure outside of guideline recommendations. Therefore, the medical necessity of the request for X is not established. Therefore, this request is not medically necessary."

Based on the submitted documentation, the requested X is not medically

necessary. There is insufficient documentation to demonstrate that the patient has X. ODG notes that X is not recommended for X. The use of X is not considered a first line treatment option. No new information has been provided to overturn the previous denials.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

Based on the submitted documentation, the requested X is not medically necessary. There is insufficient documentation to demonstrate that the patient has X. ODG notes that X is not recommended for X. The use of X is not considered a first line treatment option. No new information has been provided to overturn the previous denials. 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