



MedHealth Review, Inc.  
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## **Notice of Independent Review Decision**

### **DATE NOTICE SENT TO ALL PARTIES:**

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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: X.

X: X MRI of the X, X MRI precert request form, X clinical notes from X, X, X, and X emails from X, X adverse determination letter, X appeal adverse determination letter, X notice of approval, X notes X, X PT script, X DWC, X SUCC activities restrictions note, and X claims analysis X, MD.

A copy of the ODG was not provided by the Carrier or URA for this review.

## **PATIENT CLINICAL HISTORY**

### **[SUMMARY]:**

This case involves a X who sustained an industrial injury on X and is seeking authorization for a X. Prior diagnostic testing included MRI (magnetic resonance imaging) of the left humerus dated X has X. Previous treatments have included X (X sessions as of X).

Notice of Approval dated X approved the requested X. Early Claims Analysis report dated X has the injured worker with mechanism of injury of X. Reports reviewed included office visit notes dated X (Urgent Care) with objective findings of moderate tenderness in the deltoid muscle. The x-rays were unremarkable, and X was diagnosed with a left shoulder strain and released with work restrictions. The MRI of the left humerus was documented from X. Compensable diagnosis based on mechanism of injury is a left shoulder strain. It was opined that the findings on the MRI

from X were not included in the compensable injury sustained on X. X report dated X has X injured worker presenting for an evaluation of the left shoulder. X is on light duty. X has pain and swelling of the superolateral left shoulder. The pain is aggravated by reaching external and internal rotation. The left shoulder active range of motion is flexion X, abduction X, external rotation X, internal rotation X, and extension X. Shoulder strength is abduction, flexion, and internal rotation X and external rotation X. Elbow extension and flexion strength is X. Empty can/supraspinatus and Hawkin's-Kennedy are X. The treatment plan included X. Progress report dated X has the injured worker with moderate pain to the left shoulder. X pain is worse with lifting the arm overhead, reaching behind, and characterized as sharp. X has persistent pain with movements. There are no left shoulder objective findings documented. The treatment plan included X.

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

As per ODG, "X"

In this case, this X sustained an industrial injury on X, and is seeking authorization for a X.

Overall, X presented on X with moderate pain to the left shoulder. X pain is worse with lifting the arm overhead, reaching behind, and characterized as sharp. X has persistent pain with movements. However, detailed documentation is not evident regarding a significant change in the clinical status. No recent/updated primary treating provider documented objective findings were provided since the imaging study performed on X. There have been no invasive procedures performed since prior imaging, based on the documentation provided for review. Detailed documentation of how an updated imaging study would change/impact X current treatment plan has

not been detailed. Moreover, X is not evident. The results from the approved X are not evident. Overall, there is no compelling rationale presented, or extenuating circumstances noted to support the medical necessity of this request as an exception to guidelines. Therefore, the request for a X is not medically necessary.

**A DESCRIPTION AND THE SOURCE OF  
THE SCREENING CRITERIA OR OTHER  
CLINICAL BASIS USED TO MAKE THE  
DECISION:**

- ACOEM- AMERICAN COLLEGE  
OF OCCUPATIONAL &  
ENVIRONMENTAL MEDICINE UM  
KNOWLEDGEBASE**
  
- AHRQ- AGENCY FOR  
HEALTHCARE RESEARCH &  
QUALITY GUIDELINES**
  
- DWC- DIVISION OF WORKERS  
COMPENSATION POLICIES OR  
GUIDELINES**
  
- EUROPEAN GUIDELINES FOR  
MANAGEMENT OF CHRONIC LOW  
BACK PAIN**
  
- INTERQUAL CRITERIA**

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

**MILLIMAN CARE GUIDELINES**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

**TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**