

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 at work on X. X stated that X was working as X. The diagnoses were lateral epicondylitis, left elbow; strain of other extensor muscle, fascia and tendon at forearm level, left arm, initial encounter; and pain in left elbow.

On X, X was seen by X, MD, for evaluation of left elbow pain. X stated that at work on X, X felt a sharp pain in X left elbow. The next day, X had worsening pain. At the time, X continued to have pain along the lateral aspect of X left elbow, that was aggravated with gripping, twisting, wrist extension, and usually in the mornings when X first got out of bed. X rated X pain as a X. X had X. X had an MRI of X left elbow, which demonstrated X. Left elbow examination revealed the X. The X was moderately tender. Mild tenderness was noted at the X. Resisted movement was moderately painful with wrist extension and mildly painful with finger extension. The strength was intact at X except wrist extension was X, and grasping was X. Dr. X assessed that X had left lateral elbow pain related to X. The treatment plan was to proceed with X.

An MRI of the left elbow dated X revealed X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "ODG states that X is not recommended for X as evidence shows inconclusive benefit, lack of benefit, or potential harm. Guidelines state that X is not recommended for elbow condition. Guidelines state that X cannot be recommended due

to the low quality of the evidence and the high variability in methods and experimental procedures. In this case, evidence-based guideline does not recommend X due to potential harm. Exceptional factors to support this request outside of guidelines have not been identified. As such, the request for X is not medically necessary. X is also not medically necessary given the non-approval of surgery and as evidence-based guidelines do not recommend this procedure due to low quality of the evidence. Therefore, this request is not medically necessary.”

Per a reconsideration review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “ODG states that X is not recommended for X. The evidence shows inconclusive benefit lack of benefit, or potential harm. ODG states that X is not recommended for X. The evidence shows inconclusive benefit, lack of benefit, or potential harm. In this case. the claimant has X. The guideline does not recommend X for potential harm. Considering this the request for X is not medically necessary. As the requested X is not approved and inconclusive benefit or potential harm from guidelines, the request for X is not supported. Therefore, this request is not medically necessary.”

The claimant had been followed for a history of left elbow pain that had persisted despite the X. The physical exam findings detailed X. Review of the current evidence based guidelines and literature does not support the use of X. Exceptional factors for proceeding with the services in dispute were not present. Therefore, it is this reviewer’s opinion that medical necessity has not been established for the services in dispute: X denials are upheld and non-certified.

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

The claimant had been followed for a history of left elbow pain that had

persisted despite the X. The physical exam findings detailed X. Review of the current evidence based guidelines and literature does not support the use of X. Exceptional factors for proceeding with the services in dispute were not present. Therefore, it is this reviewer's opinion that medical necessity has not been established for the services in dispute: X prior denials are upheld and non-certified.

Non-Certified.

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