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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, was injured on X. X was X. The diagnosis was left shoulder pain (X).

X was seen by X, MD, on X and X. On X, X was seen for a follow-up of left shoulder pain. X had a X. Conservative management consisted of X. X had not made any substantial improvement in pain or function. On examination, X could forward elevate to X degrees, abduct to X degrees, externally rotate to X degrees, and internally rotate to X mid lumbar spine. There was excellent external rotation strength and supraspinatus strength. X was able to do a belly press and had good strength with bear hug testing. X noted more pain with Speed's and O'Brien's test, although tenderness to palpation was noted over the biceps and acromioclavicular joint. X also did have some pain with jerk test. The assessment included left shoulder pain, unspecified chronicity. X had X. X had X. Treatment plan was to proceed with X. On X, X presented for a follow-up of left shoulder pain with X. X surgery was denied X with minimal explanation. X noted substantial pain at night that limited X ability to rest. Conservative management has X. On examination, BMI was 42 kg/m<sup>2</sup>. X could forward elevate to X degrees, abduct to X degrees, externally rotate to X degrees, and internally rotate to X mid lumbar spine. There was excellent external rotation and supraspinatus strength. X was able to do a belly press and had good strength with bear hug testing. X noted more pain with Speed's and O'Brien's test, although tenderness to palpation was noted over the biceps and acromioclavicular joint. X did have some pain with jerk test. Due to the

failure of X, Dr. X resubmitted the request for X.

An MRI of the left shoulder dated X showed a 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 recommended for patients with X. X is reserved for patients with recalcitrant pain, marked functional limitations, and specific clinical findings such as tenderness over the acromioclavicular joint, crepitus, and pain on a cross-arm test. Imaging should also confirm X. ODG states that X is recommended X. X is a surgical option for patients with significant X. This surgery is also an alternative to direct repair for specific types of X. In this case, all clinical indications for X are not met. The records do not support a X. The records are not supportive of X. The objective exam is not supportive of AC crepitus and pain with cross-arm testing. The records do not support X. Given this, the medical necessity of X is not established. The current records are not supportive of X. Given this, the medical necessity of X is not established. Therefore, this request is not medically necessary."

Per a reconsideration review adverse determination letter dated X; the prior denial was upheld by X, MD. Rationale: "In this case, this is a X . The claimant reports left shoulder pain. Exam shows X. MRI shows a X. The provider states that the claimant has X. Given the ongoing pain that has been persistent despite conservative treatment, positive findings on exam, and imaging evidence of X, the request for X would have been medically necessary. The request for X is not medically necessary as there is of X which is required by the guidelines. There is no evidence of X. X would have been supported however as there has been no agreement to a modified treatment plan the request in total is not

considered medically necessary. Therefore, this request is not medically necessary.”

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

In this case, this is X. The claimant reports left shoulder pain. Exam shows X. MRI shows a X. The provider states that the claimant has X. Given the ongoing pain that has been persistent despite X would have been medically necessary. The request for X is also medically necessary as there is tenderness over X. There is evidence of X on MRI. Therefore, this request for X is medically necessary and recommendation is overturned.

Overtured

**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