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IRO Certificate #XX

DATE OF REVIEW: 11/28/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Physician Board Certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	**(Agree)**	**X**
Overturned	(Disagree)	
Partially Overturned	(Agree in part/Disagree in part)	

PATIENT CLINICAL HISTORY SUMMARY

XXXX. First clinic notes dated XXXX reports XX pain with range of motion. XXXX was diagnosed with a XX XX XX XX XX and referred to Orthopedics. XXXX was seen by XXXX.

Patient was then seen by XXXX. XXXX complained of pain and weakness in the XX XX. Examination showed tenderness over the greater XX, XX impingement test, pain and weakness with XX XX isolation testing, and XX range of motion. X-rays reported as XX. MRI report showed a XX of the XX. XXXX recommended XX XX surgery and XX XX.

Patient saw XXXX. XXXX continues to have pain according to the office note. There was no change in physical examination. Patient was prescribed XXXX and surgery was again recommended.

X-ray report, XX XX, dated XXXX, showed XX abnormalities.

MRI, XX XX, performed without contrast, XXXX, showed XX% XX XX XX-thickness XX of the XX measuring XX. XXXX had thickening of the XX XX. XXXX had XX XX. XXXX was noted to have an XX XX XX of the XX. There XX XX XX XX, normal XX XX, and normal XX

XX of the XX XX.

Peer reviews and adverse determination letters state that surgery was non-certified based on lack of conservative treatment with a XX XX injection and XX therapy. It was also recommended that XXXX not have XX XX performed unless XXXX had an extensive time period from the time of onset of symptoms and treatment with non-surgical methods.

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

Opinion: I agree with the benefit company's decision to deny the requested service.

Rationale: It is my opinion that the patient will benefit from a course of XX therapy for XXXX XX XX and **do** recommend a XXXX injection in the XX XX space to determine response to the injection as far as pain is concerned. The request for the service, XX XX XX, XX XX with XX/XX XX XX XX, is not medically necessary.

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

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE
AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X
MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
MILLIMAN CARE GUIDELINES
ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X
PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
TEXAS TACADA GUIDELINES
TMF SCREENING CRITERIA MANUAL
PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)
OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)