MEDICAL EVALUATORS
OF TEXAS ASO, L.L.C.
2211 West 34th St. ● Houston, TX 77018
800-845-8982 FAX: 713-583-5943

DATE OF REVIEW: **June 17, 2019**

IRO CASE #: **X**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN WHO REVIEWED THE DECISION
This case was reviewed by a physician who is board certified in Orthopedic Surgery and is currently licensed and practicing in the State of Texas.

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

☐

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Type of Document Received	Date(s) of Record
Electrodiagnostic Medicine Consultation by X, MD	X
Progress Note by X, MD	X
Status Report by X, MD	X
Special Consultation Request by X, MD	X
Texas Worker's Compensation Work Status by X, MD	X
	X
EKG Report by X	X
Surgery Scheduling Form by X, MD	X
Denial Letter from X	X
Letter of Medical Necessity by X, MD	X
Request for a Review by an Independent Review Organization by X	X
IRO Request Details from Texas Department of Insurance	X
Notice of Case Assignment from Texas Department of Insurance	X

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The claimant is a X-year-old X who was injured on X while X was X from a X and developed pain to XX. The claimant had MRI that demonstrated a complete X of the entire X of the X with moderate to marked X measuring approximately X. Subsequently, the claimant underwent X on X.

Progress Note by X, MD dated X documented the claimant was over X and X postop "from a X due to poor quality of the X that is not eligible for X occurred." The claimant complained of severe, constant pain in the X that was associated with X in the X. Dr. X documented the claimant rated X pain a X ,x. The claimant denied any previous XX problems and reported X was X needed. X-ray of the X demonstrated X and X. Objective findings on examination by Dr. X included: X was X on the X range of motion tests were normal; X (active), X (passive); X (passive); X X° (passive); and X was ">N" (passive). Strength tests on the X were normal. X strength tests: X motor power; X was X;. There was no tenderness to palpation and provocative tests were normal. Dr. X additionally reported physical exam of the X were within normal limits. Dr. X noted previous treatment consisted of X. The claimant was diagnosed with X. Dr. X recommended the claimant undergo a X.

Letter of Medical Necessity byX , MD dated X documented the claimant underwent X sessions of X which resulted in improvement for the claimant until X returned to X original job X and reinjured X X use. Dr. X reported "X
Demonstrated X."

Prior denial letter from X dated X denied the request for X
days inpatient stay due to "the patient complained of ongoing X pain despite X treatment. Examination revealed weakness and pain in X of motion. However, X was not provided for review. As such, the request forX ;X X is non-certified. The Official Disability Guidelines recommend a X. In the clinical records submitted for review, the physician requested a X as well as X. However, the request for X was non-certified: Therefore, the request for X is non-certified. Because an adverse determination for X has been rendered, an adverse determination for any associated pre-operative clearance is also rendered."

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

The claimant is a X-year-old X who sustained injury to X X and subsequently underwent X. The request is for coverage of X.

Based on Official Disability Guidelines (ODG), X is indicated for non-functioning X) [1]. The ODG criteria for the X is consistent with the standard of care and is indicated for X In this case, the records submitted for review revealed the claimant meets the criteria with documentation of X. Specifically, the claimant has a X based on X clinical exam, history of prior attempt to repair , and findings on X x-rays consistent with X, with X. In patients with X, an MRI is not needed to prove the X this can be determined based on x-rays alone. The medical records document X diagnosis, failed prior treatment including non-operative

and operative interventions, and the most appropriate next plan is for X as requested by the treating surgeon. Since the X is indicated, the requested X is also medically necessary.

Therefore, based on the ODG indications, referenced evidence-based medical literatures literature as well as the clinical documentation stated above, it is the professional opinion of this reviewer that the request for coverage of X is medically necessary and appropriate.

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

1)
Official Disability Guidelines (ODG) – Online Version
Shoulder – (updated 4/16/2019)
ODG Indications for Surgery™ -- Reverse Shoulder Arthroplasty:
XX

Hospital Length of Stay (LOS)
ODG hospital length of stay (LOS) guidelines:
XX
Best practice target (no complications) -- 2 days

2. XX
3. XX

1. XX

[kg/hp]

NOTICE ABOUT CERTAIN INFORMATION LAWS AND PRACTICES With few exceptions, you are entitled to be informed about the information that the Texas Department of Insurance (TDI) collects about you. Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However, TDI may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that TDI correct information that TDI has about you that is incorrect. For more information about the procedure and costs for obtaining information from TDI or about the procedure for correcting information kept by TDI, please contact the Agency Counsel Section of TDI's General Counsel Division at (512) 676-6551 or visit the Corrections Procedure section of TDI's website at www.tdi.texas.gov.