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Notice of Independent

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**
X: MRI of the X without contrast interpreted by XX, MD X: MRI of the X without contrast interpreted by X, MD
X: Re-evaluation by X, MD
X: PT by X, PT
X: Clinical summary by X, MD X: Pain assessment by unknown provider
X: Imaging ordered by X, MD
X: PT by X, PT X: Clinical summary by X, MD
X: UR performed by X, MD
X: UR performed by X, MD

**PATIENT CLINICAL HISTORY [SUMMARY]:**
Claimant is a X -year-old X patient who sustained an injury on X. The mechanism of injury was not documented in the medical records for review.

X: MRI of the X without contrast interpreted by X, MD. Revealed X appeared intact as well as the visualized X.
X: MRI of the X without contrast interpreted by X, MD demonstrated X retraction. There was no definite X seen, likely represented a X. X extended X was noted. There was severe X with moderate X.

X: Clinical summary by X, MD. The patient presented for X pain. X underwent X which did not give X temporary relief. X was presently receiving X.

X: Clinical summary by X, MD. The patient continued to have difficulty with

XX. X underwent X. X continued to have problems with X and also X. X had pain which radiates distally. X was not having X now in the X.

X: UR performed by X, MD. Rationale for denial: Based on the information submitted for this review this request is non-certified.

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

The request for XX XX arthroscopy, XX XX, XX XX XX, XX XX XX, XX XX XX repair is approved.

The patient is a XX year-old XX who sustained a work injury on XX. X XX MRI demonstrates a full thickness XX XX XX in the XX XX XX. X also has a complete XX of the XX XX of the XX. X XX XX XX of the XX joint with XX spurring.

The patient has been treated with physical therapy, activity modification, XX and XX injection. X has also undergone a XX XX XX XX and fusion (XX). X continues to have limited XX range of motion and weakness. The treating provider has recommended XX XX arthroscopy, XX XX, XX XX XX, XX XX repair, XX XX XX repair.

The Official Disability Guidelines (ODG) supports XX XX repair in patients with a XX XX tear who have pain weakness in abduction. The physical examination should correlate with a XX XX tear on MRI. XX XX pathology should be ruled out.

XX XX is an accepted technique for repair of a XX XX tear in a XX XX.

This patient meets criteria for surgery on the XX XX. X primary functional limitations are associated with a XX XX tear. X has severe XX XX, which would require XX XX XX. XX XX is appropriate for the XX and XX XX. X is a XX XX who meets criteria for XX XX XX XX. X XX XX has been appropriately addressed with XX, prior to surgical consideration for the XX XX surgery.

X XX injury was sustained over one year ago. X has completed conservative care for X XX injury. I do not expect that X XX XX condition will improve without surgery.

The request for XX XX arthroscopy, XX XX, XX XX XX, XX XX repair, XX biceps XX repair is found to be medically necessary.

**ODG Guidelines:**

Arthroscopy utilizes an optical scope connected to a camera, allowing clear visualization of the interior of a joint, often allowing performance of surgery through tiny incisions, resulting in faster and easier recovery.
See also Surgery; Diagnostic arthroscopy; as well as Needle arthroscopy (in-office) in the Knee Chapter.

**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**

☐ **AHCPR- 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**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**