17119 Red Oak Rd
Unit # 90333
Houston, TX 77090
281-836-6171

IRO REVIEWER REPORT
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:
This case was reviewed by a Board-Certified X

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

X

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a X with complaints of X. The MRI of X was performed on X revealed X. X was initially presented to X with complaints of X. X exam revealed X. The physician recommended X and X. The patient followed up again with X on X with reports of X but X. X had undergone X. Recommendation was made for continued X. On X, the patient reported continued X and X. Exam revealed X. Recommendation was made for X and X. This request was submitted for: X. This

case underwent 2 prior adverse determinations. On X, Dr. X found the case noncertified secondary to lack of exam findings supporting the need for requested procedures and X. On X, Dr. X found the appeal partially certified for X, but the case was noncertified as peer-to-peer contact was not conducted.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
According to the review of Official Disability Guidelines, it is my opinion that the claimant meets the X. This claimant meets criteria with documented X. The claimant has less than X. There is no imaging evidence of other X. However, according to the ODG, the request for criteria of X and X are not met. The claimant X and X findings to support the need for X and X. There is no documented X. Finally, there are no subjective clinical complaints regarding the X, no X findings regarding the X, and no imaging findings to support the need for X.

Therefore, it is the opinion of this reviewer that the requested services are partially overturned. The claimant meets the criteria for X and thus medically necessary. However, the criteria for X are not met and not medically necessary.

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

Recommended as indicated below. X (MUA) and/or X release
for primary adhesive capsulitis has more successful outcomes than when performed for X, where additional procedures should generally be avoided.
See also X (MUA) and X.
X.