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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: 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:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

I have determined that the X is not medically necessary for treatment of this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X has requested authorization and coverage for right X. The Carrier denied this request indicating that it is not medically necessary for the member's medical condition.

A review of records indicated that the member was being treated for X of the right X; tendinitis of the right X. Conservative treatment included a right X on X, physical therapy, and medications. The X magnetic resonance imaging (MRI) of the right X. The X treating physician report cited right X. There was occasional popping in the right X. The examination revealed X. There was tenderness to palpation over the lateral X. The X was X. Strength was at a level of X. There were painful X. X-rays

were noted to show X. The treatment plan was to return as needed. The X treating physician report cited right X. The member reported that it feels like X was not having as much pain but still feels a little weak. The treatment plan included MRI. The X treating physician report was a follow-up for right X MRI. The treatment plan included right X. The X treating physician report cited ongoing pain in the anterior, lateral, and superior X. The pain was worse with overactivity and reaching out front and behind X. The examination revealed X. There was tenderness to palpation over the lateral X. X was at a level of X out of X in the X. There were painful X signs. The treatment plan was again for X.

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

The Maximus physician consultant explained that as per the Official Disability Guidelines (ODG), " X injury may be indicated for 1 or more of the following: X

This X was being treated for impingement syndrome of the right X; tendinitis of the right X. The member presented with ongoing pain in the anterior, lateral, and superior X. The pain was worse with overactivity and reaching out front and behind X. The examination revealed X. There was tenderness to palpation over the lateral X. The X was X degrees in X and X degrees passive; X was X degrees active and X degrees passive. Strength was at a level of X. There were painful X.

However, detailed documentation was not evident regarding diagnostic imaging evidence supporting any X. ODG guidelines do not support X. The x-rays were noted to show X. There was no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception to guidelines. Therefore, the requested coverage for X is not medically necessary for the treatment of the member's condition.

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**

☐ **AHRQ-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:**
Shoulder: Surgery for Rotator Cuff Repair, Shoulder Conditions; Surgery for Impingement Syndrome (Bursectomy, Debridement, Acromioplasty, Subacromial Decompression), Shoulder Conditions; Surgery for Biceps tenodesis (or Tenotomy), Shoulder Conditions; Surgery for AC Joint (arthritis, separation), Shoulder Conditions

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE**

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