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

Notice of Independent Review Decision

DATE OF REVIEW: X
Date of Amendment: **X and X**

IRO CASE #: **X**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

X.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN WHO REVIEWED THE DECISION

The professionally certified health care provider is board-certified in 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

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EMPLOYEE CLINICAL HISTORY [SUMMARY]:

Mechanism of injury:
The claimant is a X who was injured on X while X. The claimant was diagnosed with distal left bicep tear.

Diagnostic studies:
The claimant underwent an MRI of the elbow from X on X with the following impression: tear of the distal biceps tendon dear its radial tuberosity insertion with retraction near the level of the radiocapitellar articulation. There is strain within the torn tendon extending into the musculotendinous junction. Elbow joint effusion. X also underwent an MRI of the elbow from X on X with the following impression: Prominent X. Infection with X. Moderate X. The upper aspect of the X. Biceps tendon intact onto X. Mild common X. No X. No X.

Surgeries:
The claimant underwent X on X.

Conservative Treatment:
No documentation of any X was provided.

Medications:
The claimant is currently X.

Progress notes:
Visit Note by X dated X documented the claimant to have complaints of left elbow pain. The Objective documents that there is not interval change in the claimant's health and X would like to proceed with X. The claimant was diagnosed with distal left biceps tear X was recommended.

Visit Note by X dated X documented the claimant to have complaints of left elbow pain. The Objective documents that the claimant is X days post-op and is doing well. The claimant was diagnosed with a left distal biceps tear and a X was recommended.

Visit Note by X dated X documented the claimant to have complaints of left elbow pain. The Objective documents that the claimant is X weeks post-op and is still doing well. The claimant was diagnosed with a left distal biceps tear and X was recommended.

Visit Note by X dated X documented the claimant to have complaints of left elbow pain. The Objective documents that the claimant is X weeks post op and is doing well but has pain in x 1st extensor compartment and forearm. The claimant was diagnosed with a left distal biceps tear and X was recommended.

Visit Note by X dated X documented the claimant to have complaints of left elbow pain. The Objective documents that the claimant is X weeks post-op and is still having pain in x forearm. The claimant was diagnosed with left distal biceps tear and X was recommended.

Denial Letter:
Prior UR dated X denied the request for X "A left elbow MRI dated X showed X There was X. According to the most recent note, the claimant had a limited X. X extension. However, it is unclear why X is necessary. There continues to be no exceptional factors to support X. As such, the requested Appeal Request: X is not medically necessary supported."

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

The claimant underwent X. The claimant was documented to maintain full elbow flexion and extension. Radiographs did reveal X. The peer-reviewed literature documents a X. The claimant had not yet reached the X months X. Because X was maintained as X, a X was not indicated as requested. There are no ODG guidelines support for X. The same guidelines do not support X. In summary the request for X is not medically necessary.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

ODG Criteria