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Austin, TX 78758 **IRO Certificate #X**

Notice of Independent Review Decision

DATE OF REVIEW: X

IRO CASE NO. 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) X

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY SUMMARY

The patient is X who has requested a X and has been denied as being medically unnecessary. The patient sustained an injury of X right shoulder, X, while X. An X was performed on X showing X. Patient saw X, an orthopedic surgeon, who treated X with X. Dr. X requested a X to be performed based on the fact that X was unable to see the X. Dr. X felt that the need for a X was not necessary.

An appeal reply dated X was generated by X, MD. X reviewed the history and X was not medically necessary stating that the imaging report did not demonstrate that the quality was poor and that there were no new clinical changes after the X.

I also reviewed an appeal letter dated X from X at the office of X, X, requesting the X to allow Dr. X to determine the proper treatment for the patient. A clinical note dated X by Dr. X reviews the patient's history, including the work injury occurring in X, when the patient complained of pain and goes over the X report showing a X. X note ***does*** say in X review
the X did not show the medial portions of the shoulder including the X and that X was unable to perform a X.

PATIENT CLINICAL HISTORY SUMMARY (continuation)
X performed X, X, interpreting physician Dr. X X, showed a X.

Summary: X injured X right shoulder at work resulting in a X. X also appears to have preexisting changes in the X.

According to Dr. X, X is unable to determine the amount of X. X is requesting a X.

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

Opinion: I disagree with the benefit company's decision to deny the requested service(s).
Rationale: I agree with Dr. X that an X. X that are X. It would be amenable to non-surgical repair. In my opinion, X are valuable to determine the X.

The requested service, X, is reasonable and medically necessary for the patient.

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

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL

MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

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