MET HEALTHCARE SOLUTIONS
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Notice of Independent Review Decision

X:

IRO Case number: X

Description of the services in dispute

X.

Description of the qualifications for each physician or 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)

Provide a description of the review outcome that clearly states whether **medical necessity exists** for **each** of the health care services in dispute.

Information provided to the IRO for review

X

Patient clinical history

The claimant is a X diagnosed with bursitis of left shoulder (X). X was also diagnosed with status post arthroscopy of left shoulder (X). This review is to determine the medical necessity of X.

According to the Prescription by X dated X the claimant was injured on X. X date of X. The Letter of Medical Necessity within this document stated that Dr. X, MD attested to the X to be medically indicated and medically necessary for the claimant. Additionally, the X, "…is medically necessary for my patient for the purpose of X." The length of time the doctor requests is for X. The doctor also requests X.

The Office Note by X, MD dated X stated that the claimant presented for a X on X. The document further stated that, "X has been compliant with X. Denies falls or trauma. Has been compliant with X. X has X." X pain level was reported to be X on the pain scale. The assessment and plan stated, "We will enroll X in X. We will start X. We will also work to get X. X will remain off duty at this time. Work comp. form provided."

The Letter of Medical Necessity by X dated X stated that the claimant had used the X. X noted that the X, "…not only minimized pain, but assisted on advancing my range of motion and mobility of my shoulder joint…" X continued to use the X. X continues to make progress through X.

Denial Letter by X dated X stated that, "This correspondence pertains to the review of the following health care service(s). As

requested, a second contracted physician who was not involved in the original non-certification has reviewed the original information, supplemented by additional medical records submitted and/or peer discussion(s) with the treating provider. The second physician has upheld our original non-certification. Specific Request: Appeal X: Appeal Upheld by Physician Advisor".

Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision

The claimant is a X diagnosed with bursitis of the left shoulder. X was previously diagnosed with status post arthroscopy of the left shoulder. This review aims to determine the medical necessity of the X.

X. However, according to ODG guidelines, there is no evidence showing the superiority of X. Therefore, this decision is upheld based on these guidelines and lack of medical necessity.

Description and source of the screening criteria or other clinical basis used to make the decision

☐ ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase

☐ AHRQ - Agency for Healthcare Research and Quality Guidelines

☐ DWC- Division of Workers Compensation Policies or Guidelines

☐ European Guidelines for Management of Chronic Low Back Pain

☐ InterQual Criteria

☐ Medical Judgment, Clinical Experience, and Expertise in Accordance with Accepted Medical Standards

☐ Mercy Center Consensus Conference Guidelines

☐ Milliman Care Guidelines

☐ Presley Reed, The Medical Disability Advisor

☐ Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters

☐ TMF Screening Criteria Manual

☐ Peer Reviewed Nationally Accepted Medical Literature (Provide A Description)

☐ Other Evidence Based, Scientifically Valid, Outcome Focused Guidelines (Provide A Description)

☒ ODG - Official Disability Guidelines & Treatment Guidelines