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Notice of Independent Review Decision

Send to:

IRO

Reviewer

Report 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

A physician reviewer, board-certified in X, reviewed the case. The reviewer has the scope of licensure that typically manages the medical condition, procedure, treatment or issue under review and current relevant experience, and/or knowledge to render a determination for this case. The reviewer attested in writing to his/her licensure and the absence of any conflicts in determining this case.

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.

X

Information provided to the IRO for review
X

Patient clinical history
X, date of birth X, is an X diagnosed with left shoulder rotator cuff tear with impingement syndrome and synovitis and seeking coverage for X; cost is X; prior authorization needed only if DME cost is greater than X; Left shoulder arthroscopy with extensive debridement, arthroscopic decompression, possible subpectrol biceps tendonesis (X). The claimant reported an injury on X after X. The claimant described pain at the left shoulder. The claimant was initially

referred to X. The claimant X through X. The claimant had used X. The X left shoulder MRI report noted mild X. There was X noted. The X evaluation noted limited range of motion of the left shoulder in all planes on the physical exam. The rest of the evaluation for the left shoulder was deferred.

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

The proposed surgical procedures were denied by utilization review which noted there was no indication to proceed with X. Upon review of the clinical findings, the claimant continues with left shoulder pain with limited range of motion X. Imaging did note X. The current physical exam did note a X. There are indications for surgical intervention based on current evidence-based guidelines and the medical literature as evidenced in the Official Disability Guidelines (ODG) for Shoulder Section Updated X. The claimant has ongoing functional limitations due to the noted X. However, there are insufficient clinical findings to support the need for X. Therefore, approval in part is recommended for X. X are not medically necessary. Thus, the denial is partially overturned.

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

■ ODG - Official Disability Guidelines & Treatment 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)