

## Notice of Independent Review Decision

**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 determination should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

X

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a X. X felt several pops in the shoulder with the injury. X has documented pain, limited range of motion and weakness of the right shoulder since the injury. The most recent office visit note from X states that on physical exam the patient had limited active motion in X. X-rays from this visit are stated to be essentially normal with just X. X has had an MRI dated X that showed X was noted on the MRI and no X or exam findings were documented. Treatment to this point has consisted of X.

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

Per ODG references the requested "X" is medically necessary, " possible X " is not medically

necessary.

While ODG guidelines recommend X months of X. There is allowance for X. With the available information this patient has an injury description consistent with an X. With this seeming to be an X. The patient has imaging findings consistent with X. While it is possible to find other X. I would recommend that the X. If findings are seen at the time of X.

**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 KNOWLEDGE BASE
- AHCPR- 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
- 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 A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES