

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 determinations 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]:

Patient is a X with a date of injury of X. Patient was diagnosed with chronic pain syndrome of the left shoulder. Mechanism of injury was sustained when X. Patient was treated with X. Did not try X. Patient continues to complain of pain and describes X pain as X. Physical exam revealed 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 not medically necessary.

ODG references do not recommend X. Also, in the note dated X, it is stated that the provider reported patient had X. The provider reports that the patient does not have any neurological deficit in the left arm. Based on the information provided, there is no documentation on the X; therefore, X is not certified.

**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