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Notice of Independent Medical Review Decision

Reviewer's Report

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

M.D., Board Certified in Physical Medicine & Rehabilitation/Pain Management.

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)

I have determined that the requested is not medically necessary for the treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated X.

2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated X.
3. Notice of Assignment of Independent Review Organization dated X.
4. Health Plan denial letters dated X.
5. Request for an external medical review from client dated X.
6. Predetermination request with letter of medical necessity dated X.
7. X TW Rehabilitation prescription documents dated X.
8. TDA Establishment Registration & Device Listing.
9. Health Insurance Claim Form signed.
10. Appeal response letter from patient dated X.
11. Pre-Authorization request dated X.
12. Successful cases list dated X.
13. Claims history list.
14. Duplicate records.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant sustained an injury in X when X was X while working as a X.

X sustained X. X underwent an X after X injury.

An MRI scan in X showed findings of a X with X. X underwent an X on X. A repeat X showed findings of X which had improved.

After surgery, X was still unable to X. During the procedure, X had decreased X SSEP testing. X had X with a suspected X.

X was admitted for X on X. X had an incomplete X at the X level. X was unable to X or X. X was using a X and performing X at a modified independent level. X was able to perform XX X with supervision using a X and transfer to X with minimal assistance. X was able to perform X at a modified independent level. X was able to transition from X with minimal assistance but required X assistance to remain X. X was only able to tolerate X.

X was expected to be able to tolerate a X program of up to X minutes with use of a X.

X was considered at risk for X, X, and X as well as altered X.

X relevant past medical history includes X, X, X, and X, and X is X with a body mass index of X

Purchase of an X was requested on X.

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

The claimant has an incomplete X as described above.

In terms of recovery after X, most recovery occurs in the first X. However, recovery can extend X, and X recovery continues for perhaps up to X. In this case, the claimant was X status post-surgery when the request was made. X would also be expected to improve, as X has an X.

In terms of functional abilities, the claimant should be able to use X for X and an X or X exercise as X is currently using a X and there is already a plan to use a X.

The requesting provider notes risks of X, X, and X. Use of the requested X would carry potential risks of pressure X, X, X, and X, as well as other X.

X conditions include X, which would also increase X risk of pressure X. X history of X and X would be relative X to using X versus X.

The X would not treat the claimant's X and is being requested as a X measure and means of exercise. Although exercise is beneficial and highly recommended, it is considered no more medically necessary in this case than for any other individual.

X is addressed by ODG in the XX and XX chapter.

X has potential advantages of more sustained training sessions and X. Other types of equipment such as X have also been promoted without much scientific evidence. Use of X as a primary modality alone does not have good evidence.

X XX may be considered as an adjunct for X during supervised X, but is not recommended alone or for X

Most commercial insurance plans exclude coverage of X including X.

It is not medically necessary or appropriate for the treatment of this claimant's condition.

Therefore**,** I have determined the requested is not medically necessary for treatment of the patient's medical condition.

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 UM KNOWLEDGEBASE**

☐ **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**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

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