Applied Resolutions LLC

Notice of Independent Review Decision

Case Number: XX Date of Notice: 3/18/2019 2:08:30 PM CST

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IRO REVIEWER REPORT

Date: 3/18/2019 2:08:30 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX XX XX #XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: XX

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]: XX. XX XX is a XX-year-old XX who was injured at work on XX. XX was XX in the XX by a XX that XX the XX; the person XX XX XX XX, injuring the XX XX, XX, and XX XX. XX reported, "XX XX XX XX," stating XX was XX to go anywhere at XX and being at XX XX. XX. XX had a history of being treated for XX XX for well XX a XX prior to XX / XX XX XX. The ongoing diagnoses were XX XX XX, XX XX, and XX XX XX. On XX, XX. XX was evaluated by XX. XX presented informing that XX continued to be XX and understandably unsettled about returning to work. XX felt it was reasonable to recommend XX not return to XX employment for XX to XX XX and that XX return to the office to a XX in XX to XX weeks for reassessment. XX recommended that XX. XX meet with XX XX XX at least XX to XX times to work on processing the event. XX (XX) and XX XX were prescribed. The poorly scanned records were largely illegible. Per utilization review determination letter dated XX, the request for XX XX XX XX #XX was not certified. It was determined that the injury was XX days old and XX. XX was XX in the XX by a XX that XX the XX, and XX XX XX XX XX, injuring XX XX, XX and XX XX. The diagnosis included XX XX. XX sustained injuries to XX XX, XX XX and XX XX. According to the Official Disability Guidelines XX, XX was not recommended as a first-line treatment. As such given the clinical information provided, there was a lack of significant abnormal physical examination findings, the request was not medically necessary at the time. The poorly scanned records were partially legible. A letter dated XX indicated that the reconsideration request was denied/non-certified. Rationale: The proposed treatment consisting of XX XX was not appropriate and medically necessary for this diagnosis and clinical findings. XX was (XX) not recommended as a first-line

treatment. There was insufficient evidence to recommend atypical XX as XX in conditions covered in Official Disability Guidelines. It may be useful to augment XX treatment in treatment refractory patients. XX XX (XX) XX mg # XX was not appropriate.

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

XX is an atypical XX medication that is not recommended for 1st line use to treat XX or XX. There is very limited objective evidence of significant XX. A majority of the records provided were of very poor copy quality. There were no inventories provided for review. The records did not include a specific XX assessment. There was also no clear indications that the claimant had tried and failed to respond to 1st line XX that are typically prescribed for XX and XX conditions.

Therefore, it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld.

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

☐ AHRQ- 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 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

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

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

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL