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IRO REVIEWER REPORT

Date: 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: X

PATIENT CLINICAL HISTORY [SUMMARY]:
X with date of injury X. X was injured at work X. The diagnoses included X. X was seen by X, MD on X for evaluation of X. The pain was described as X. X pain had been relieved X. X had X. This was X. X was on X. X had X. X had X. X was X. X wanted to proceed with a X. Assessment was X. Dr. X opined that X had an X. Per a letter dated X by Dr. X, X had a X. The pain was X. X was on X. X had X. X had X. X was X. X wanted to X. X was approved to be seen for office visits X. Dr. X opined that X. X presented to Dr. X on X for evaluation of X. The pain was most X. Pain prior to medications was rated X. X pain had been relieved X. The amount of pain relief obtained from the X. X had X. X worked on X. X medications were providing X. X felt X activities of daily living had X. Prior X had provided approximately X. Assessment was X was recommended. Per a X Evaluation dated X by X, PhD for assessing Mr. X candidacy X, Mr. X indicated X had been under the care of Dr. X for X. X had X. The pain was localized in the X. It was X. The pain was X. X felt X

was functioning at about X. X included X. X had lack of X. The X evaluation was otherwise X. The assessment was X. Dr. X opined there was X. Dr. X opined that X was the most significant X. Treatment to date included medications (X). Per a Peer Review dated X by X, DO, the request for X was deemed medically not necessary. The rationale noted that the most recent documentation provided was from X. At the time, there was no documentation of X. Therefore, the request for X was not medically necessary. Per a Peer Review dated X by X, MD, the requested appeal for X was non-certified. Dr. X noted the following: "Per the records submitted for review, the provider thought that the patient had an X. The provider reviewed the rationale behind keeping the X. However, this is not an indication justified by ODG. In addition, a X should not be ordered by a X. Therefore, the requested appeal X is not medically necessary. For this reason, the previous determination is upheld ad remains non-certified."

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

Based on the clinical information provided, the request for X: Implantation of X is not recommended as medically necessary, and the previous denials are upheld. Per a Peer Review dated X by X, DO, the request for X was deemed medically not necessary. The rationale noted that the most recent documentation provided was from X. At the time, there was no documentation of X Therefore, the request for X was not medically necessary. Per a Peer Review dated X by X, MD, the requested appeal for X was non-certified. Dr. X noted the following: "Per the records submitted for review, the provider thought that the patient had an X. The provider reviewed the rationale behind keeping the X. However, this is not an indication justified by ODG. In addition, a X. Therefore, the requested appeal X is not medically necessary. For this reason, the previous determination is upheld ad remains non-certified." There is insufficient information to support a change in determination, and the previous non-certification is upheld. Per X evaluation dated X, the patient had a X. There is no clear rationale provided to support another X.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the decision is 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

☐ TMF SCREENING CRITERIA MANUAL