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IRO REVIEWER REPORT
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 sustained a work-related accident when X placed the X. The diagnoses were X. X. Per a Statement of medical necessity dated X by X, MD, X presented with X. X and X limited X function in X. X was noted in the X. Limited X was observed. X required X. A X was medically necessary to protect the X. Restoring more X. The custom X would provide a X. X delivered by X with specialized training and expertise in X. X were recommended as needed to maintain the function of the prescribed X. The treatment to date consisted of X. An Initial Adverse Determination letter was documented on X by X, MD. The requested services X was non-certified. Rationale: “Due to the insensate nature of X, they are generally not recommended for the X. There are no physician notes provided indicating X. There was a successful peer call. The provider stated the X. In general, however, the lack of sensation with a X. The medical necessity of the

request has not been established per the ODG guidelines based on the case details or peer call. Therefore, the requested X is not medically necessary or appropriate." A written request for appeal was placed by X CP (Clinical Manager) on X to further justify the medical necessity of a X for X that was proposed in their original request dated X stating X presented with X. The prescribed X was selected for X based on X primary need for the X. X was trying to obtain gainful employment as a X. This type of job required X to interact with clients. Being that X. Per the denial, "Due to the Insensate nature of X, they are generally not recommended for the X." While this device may not provide "X" to the injured X, it did provide the X. This is important factor when X. Based on the quoted ODG X, (Updated X). a X may be considered medically necessary. Per a Notice of Reconsideration letter dated X by X, DO, the requested services X was non-certified. Rationale: "In this case, X has complaints of pain, which X. However, an X examination was not provided for review. As a result, the requested X is not medically necessary. Therefore, this request is recommended non-certified."

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

The claimant suffered X. Per the updated information, the X were being recommended to improve the X. The records did not include any formal assessment of job functions that could be improved by X. Otherwise, the use of the X would be considered X.

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

☐ TMF SCREENING CRITERIA MANUAL