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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: Pain Medicine

REVIEW OUTCOME:

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

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X was on a X. The diagnoses were X. X presented to X, MD on X with X. Per note, X was X. There was X. X was X. X was X X had X. Dr. X recommended proceeding with X. On X, X had X. The X was rated X. It was noted that the X as well as the X had been denied. On examination, X was X. X were X. X had X. The X was decreased by X. The diagnoses were X. The plan was to appeal the denial of X. X was placed on X. On X, X rated the X. X was X. X had X. X was X by approximately X. The plan was to appeal the denial of X. An MRI X dated X identified X. An MRI X on X identified X. An MRI X on X identified. Treatment to date included X.

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

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. The initial request was non-certified noting that per Official Disability Guidelines, "Diagnosis of X." Within the documentation available for review, the patient has clinical and MRI findings consistent with a diagnosis X. Also, the patient has tried X. The requested X would be medically necessary; however, as this is a X, the request is non-certified. In regards to X, the patient has X. The request is not recommended to patients with X. The denial was upheld on appeal noting that the available documentation X. The provider is requesting X. In regards to the X, the examination on X demonstrated X. While there is X. There is no indication of current X. There is no evidence that X. Furthermore, there is no documentation of X. There is insufficient information to support a change in determination, and the previous non-certification is upheld. Note dated X indicates that the patient has X. The patient was taking X. On physical examination X has X. X with X testing. X or X with testing of the X. Note dated X indicates that symptoms X. X pain X. On physical examination X shows X. X is rated as X. X is intact X. There is X. The Official Disability Guidelines note that X are limited to patients X; however, this patient is noted to present with a diagnosis of X. Office visit note dated X indicates that X. X takes X only as needed. X has X raising X. Additionally, the submitted clinical records indicate that the request includes a request for X; however, there is no documentation of 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