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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

Physician, Board Certified in X

REVIEW OUTCOME

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

X

I have determined that the requested authorization and coverage for X not medically necessary for treatment of this patient's condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the office visit note dated X, the patient presented with complaints of x. X pain score on the office note dated X. The patient's treatment to date has included X. The patient reported that X have X on the X with no X and X did not show evidence of X related to pain medication treatment. The X examination of the X showed X and X. The provider noted that the patient has X with X. The patient was given prescriptions for X. There was no X provided or documented in the records provided for review. There was also not X agreement in the documents submitted for review. The patient was advised to return for a follow-up in X.

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

Based on the information submitted, the patient has not had X.

The 2020 ODG states that "A lack of clinically meaningful improvement in function is a reason for discontinuing X. A X improvement in pain and function is considered clinically meaningful."

The patient's pain score was X taking X and X. X pain score the year before was X. This is not X of X. There was no information submitted by the provider to indicate how X were improving X pain levels and function to support X. The issue of X was not addressed in the information provided. Additionally, there was no X provided to verify compliance. Therefore, X is not medically necessary.

X and X do not appear to be providing X and are not medically necessary.

Therefore, I have determined that authorization and coverage for X and X is not medically necessary for the 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**

- ☐ **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 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**

☐ **TMF SCREENING CRITERIA MANUAL**

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

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