

AccuReview

An Independent Review Organization

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[Date notice sent to all parties]: 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:

This physician is board certified in X.

REVIEW OUTCOME:

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

X

Provide a description of the review outcome that clearly states whether **medical necessity exists** for **each** of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

X: MRI X. Impression: 1. X. No X

X: History & Physical dictated by X: X and X. Claimant is a X who reported symptoms began on X when X was X and X. After X injury, X went to X. X how has X

into X into X. X pain in X. X notes X more than X. X noted X with X. Assessment: X. Impression: 1. X at each level. 2. X. 3. Persistent X post injury. X has completed X and is taking X as well as possible X early on and this has not resolved. Plan: X prescribed and repeated, X may continue to work X as X has been X in a different X with different X. Requesting auth for X.

X: Procedure Note Medicine dictated by X, DO. Procedure X. Follow up in clinic in X.

X: History & Physical Medicine dictated by X: follow up after X. X reported following the X. The X has X but still X. X: X. Assessment: X. Plan: claimant is X. For this reason, requested a X. Will request through Workers' Comp. In interim, start X and X. Return to clinic for X.

X History & Physical Medicine dictated by X, DO. CC: X. Claimant reported feeling X. X now has X. X is X and X. X admitted to a X today in office. X reported X. X is currently working with X. X: X to X. Assessment: X. Plan: X. Claimant suffered a X. X are secondary to X. Will request authorization for X. Continue X. Will reconsider restarting X if needed. Will consider repeating X.

X Order Note Medicine dictated by X, DO. X-Ray X: reviewed X x-ray of X.

X: History & Physical dictated by X, DO. CC: X, constant and X. X radicular X. X noted X. X admits to X. X completed X. X: pain in all directions with X. Assessment: X. Plan: Since X last visit X symptoms have been getting X. Pain is X across X. X could be due to a X; however, X symptoms are primarily X which may be causing referred pain to X. Will request auth for X for diagnostic purposes and consideration for X.

X: History & Physical dictated by X, DO. CC: X. X pain is X. X is X and X. X reported having X. X reported X. X has been out of X. Assessment: X. Plan: Claimant has some X. Will request for X.

X performed by X, MD. Reason for denial: ODG recommends X as a X. X must be well documented, along with objective X. Repeat X should require documentation

that previous X and X. The claimant complained of X. Physical exam revealed X and X. MRI revealed X. The claimant was recommended to X, however there was no documentation of X. Therefore, the request for repeat X is non-certified.

X performed by X, MD. Reason for denial: ODG supports repeat X if the X and X. Within the medical information available for review, there is documentation of a request for X. Additionally, the claimant had a previous X. Also, there is a previous X. The claimant has X. However, despite that the previous X, there is X. As such, the currently requested X is not medically necessary. Recommend non-certification.

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

Denial of X is UPHeld/AGREED UPON since a previous X did not X as recommended by the ODG guidelines, nor was there documentation of X. There is also confounding information regarding X and no documentation of results of previous X. Therefore, X is deemed not medically necessary, and after reviewing the medical records and documentation provided, the request for X is denied.

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
- PRESLEY 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)