CASEREVIEW

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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:
This physician has over X 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]:
The claimant is a X who was injured on X. X sustained a X. This was followed by a course of postoperative therapy. The diagnoses included X.

On X, the claimant presented for a X with complaints of X. X reported a pain level of X with X and also X. Objective Exam: X. Reported difficulties with X. X also has difficulty with X. Decreased X. Decreased X. Decreased X. A request for X

On X, X UR. X for Denial: The guidelines allow for X of X. This X has received authorization for X to date. The requested X additional treatments exceed X guidelines. During my discussion with the provider X stated that X would look into a return to work program such as X. Therefore, the proposed treatment X is not medically necessary.

On X, X performed a UR. X for Denial: In this case, X reveals a X. The X reports difficulty X. X reports difficulty X. There is decreased X. The provider recommended X additional X, which was denied by peer review with the X that the provider would consider a return to X. The provider then submitted a request for X hours of X which was denied by peer review. The X was that there are no MD notes provided for my review with detailed and X. The X has X. My previous denial of additional X to address these complaints is unchanged and the X would benefit from a X. Therefore, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Determination: denial of additional X for X is UPHELD/AGREED UPON since the request exceeds X recommended number of visits and time frame for submitted diagnosis, and clinically after completion of X. There is also no documentation of instruction X. Therefore, the request for X is not medically necessary.

PER ODG:

X -
Allow for X frequency (from up to X or more per week to X or less), plus X. More visits may be necessary when X

X):
Medical treatment: X
Post-surgical treatment: X
X):
Medical treatment: X
Post-surgical treatment: X
X):
Minor, X
Post-surgical treatment: X
X):
Medical treatment: X
Post-surgical treatment: X
X
Medical treatment: X
Post-surgical treatment X
X:
X
Post-surgical treatment: X
X
Post-surgical treatment: X
X):
Medical treatment: X
Post-surgical treatment: X
X:
Medical treatment: X
Post-surgical treatment: 14 visits over 12 weeks
X:
X
X:
Post-surgical treatment: X
X:
Post-surgical treatment: X
X:
Medical treatment: X
Post-surgical treatment: X
X
X

X:
Medical treatment: X
Post-surgical X
X:
See also X).
X
Post-surgical X
X:
X:
Post-surgical treatment, X
X:
Medical treatment: X
Post-X
X
X:
Post-X
Post-X
Post-X
X:
Post-X
Post-X
Post-X
Post-X
Work conditioning (See also Procedure Summary entry):
X
X:
Medical treatment: X
Post-surgical treatment X
X:
X
X
X

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)