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 is a Board-Certified 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 sustained an injury on X. X was in a X where the X. X was taken to the ER where X. X-rays of X and X were X. X attended X, but felt it was not helping. An X was done and reported X.

On X, MRI X Impression: 1. X. 2. At X, there is a X to X, which X. 3. There is no X. There is X on this exam.

On X, the claimant presented to X, X with no change in X pain level or in X symptoms to X. Pain continued to be X. X was continuing X but still had X. Exam of X. X was X with X. X was X. For the X there was X and X. X both X. X with pain X and X. Pain X the X and X.

On X, the claimant presented to X, MD for evaluation of the X. X release was discussed.

On X, the claimant presented to X, X with no change in X pain level or symptoms. Pain continued to be X. X also reported X was unable to X. X referral was denied. Referred to pain management.

On X, the claimant presented to X, MD. X was wondering why X had not gotten more X because the X. On exam, there was X. There was X. Plan: X. Await evaluation by pain specialist before planning more X.

On X, the claimant presented to X, MD for X and X. X reported X. The pain X. Physical Examination revealed X. X and X. Good X. X pain was quite X on the X. X was unable to place X hand X. X was unable to X. Assessment/Plan: X. Request X. If these are successful, X.

On X, MD performed a UR. X for Denial: The Official Disability Guidelines (ODG) supports X if there is X that is X and at no more than X. There is failure of X treatment (including X) prior to the procedure for at X. There is no previous X procedure at the planned X. There are no more than X are X. Within the medical information available for review, there is documentation of a request for X. However, the patient has X. Additionally, given an incomplete report, there is no

objective evidence point to a X. Also, it is not clear if the patient has failed other treatments. As such, the X is not medically necessary and is not certified.
The Official Disability Guidelines (ODG) supports referrals if there is documentation that X and X has been exhausted within the treating physician's scope of practice. Within the medical information available for review, there is documentation of a request for X specialist referral. However, given that the provided medical report is incomplete, there is no clear X supporting the request. As such, the request is not medically necessary and is not certified.

On X, MD performed a UR. Rationale for Denial: The available documentation indicates that the claimant complains of X. According to the X evaluation the claimant states X has not had any X. Due to lack of documented failed conservative treatment including X, the requested X cannot be justified at this time. The request was previously denied on peer review and there is no new submitted documentation to support reversing the prior determination. Therefore, medical necessity has not been established an X. This request is recommended non-certified.

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

The request for X and X is partially overturned. The request for an X specialist referral is medically necessary and meets ODG recommendation. The request for X is not medically necessary and therefore denied. The available documentation indicates that the claimant complains of X. According to the X evaluation the claimant states X has not had any X directed to X. Due to lack of documented failed conservative treatment including X, the requested X do not meet ODG recommendation and cannot be justified at this time.

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)