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:

This provider is board certified in X with over X years of experience.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

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

PATIENT CLINICAL HISTORY [SUMMARY]:

X: Progress Note dictated by X, MD, PA. CC: X. X who is X presented with complaints of X pain. Claimant stated that the symptoms started about X years ago and since has X. The pain frequently X. X reported a work injury on X. X. X pain X

described as X which is never completely X. Pain is associated with X. Pain is worsened by X. Pain improves with X. Previous treatment includes X. X: X: X pain X. X Exam: X: X. X. MRI X: X. There is no evidence of X. The visualized X. The X is unremarkable, X. EMG Impression X: 1. There is X. 2. Nonspecific X. 3. Nonspecific, isolated EMG findings observed in the X. X cannot be ruled out, although the latter is rare. 4. Isolated findings that may indicate but provide no definite X of a X. 5. There is no X. X: 1. There is evidence consistent with X noted on EMG, indicating X. 2. There is no X. Assessment and Plan: 1. X controlled. 2. X controlled. 3. X controlled. 4. X, controlled. Plan: will start with X as follows: X.

X: Prescription dictated by X, DO. RX: X. Activity X.

X: Encounter Note dictated by X, DC. CC: back pain, X. Claimant suffered work injury on X after X. Seen at X. X on X and then presented prior on X with X. Reported pain is X. Stated that it is X. Reported difficulty X. X pain is reported to be X. X pain is reported to be X.X: X: X: X reveals X is X. X. X is decreased at the X. X. X: X reveals mild to moderate X. X is moderately restricted with pain. X: X of the X revealed mild to moderate X. X testing is X. X was X. DTR was X tests were X. DX: X. Plan: Claimant did present with script for X from X and informed that pre-authorization will be needed. Discussed X and confirmed future appointment with X with Dr. X, as X was denied the X procedure but still needs to follow up. (Previous Plan of Care noted: X claimant had X visits over the X. Will resume at X. X, claimant continued to have X with pain levels increasing with activity longer than X minutes. X, due to continued X requested for the X including X, discussed approved X sessions for the X. Active care will be done for X to increase X. X Pain Management requested X. X, EMG reviewed and discussed additional X denied due to X pending. X, reviewed X.)

X: UR performed by X, DO. Reason for denial: Request non-certified. ODG recommends X. The guideline recommends X. In this case, the claimant complained of X. The claimant reported X. Upon examination, there was X. Claimant did report improved X. However, there is no documentation of the X to include X. There is no documentation of significant remaining X. There is no indication on why the claimant was X. As such, the request for X is not medically necessary.

X: UR performed by X, MD. Reason for denial: The reconsideration request for X to the X is not recommended as medically necessary. ODG recommends X. The guideline recommends fitting of treatment frequency directed towards X. In this case, the claimant complained of X. The claimant reported X. Upon examination, there was X. The X was X. The X was X to X. The claimant reported X. However, there is no documentation of the previous sessions to include X. There is no documentation of significant remaining X. There is no indication on why the claimant was unable to continue a X. As such, the request for X is not medically necessary. There is insufficient information to X, and the previous non-certification is upheld. There is X completed, dates of service and patient response. There are no X. There are no contraindications to a X documented. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

X: Progress Note dictated by X, DO. CC: X. Claimant has suffered a work injury on X, due to constant pain, X. X: X: pain X noted, X. X all listed X. X: X pain worse with X. X pain X. Assessment: displacement of X. Plan: discussed prognosis with claimant and at this time will continue X. Still recommend X of the X and X. Claimant has tried and X as it is medically necessary due to X. No surgical indications. Start X – X pain, X program, X. Claimant will continue to be X due to X.

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 the request exceeds ODG recommendations and time frame for submitted diagnoses related to an injury nearly X years ago, and there is lack of clinical information. There is record suggesting participation in X approximately X. More recently there is record of review of a X with no reported X, but notably no record of compliance with this X. There is no record of current X. At this point given record of a X, there is question of any further X prior to consideration of progression to a X. After reviewing the medical records and documentation provided for request for X is not medically necessary and therefore denied, non-certified.

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

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)