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An Independent Review Organization
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Notice of Independent Review Decision

Amended Letter

Sent to the Following

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: X

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

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X sustained an X on X when X in the X and X. The X immediately got X and X. X was diagnosed with X, X, and X. X presented for a follow-up visit to X, PA on X complaining of X and X. X reported that following the injury, X had tried to X but the X and stated X. X had tried X but X. X used a X. X was X. X was X until X. Examination showed X about the X and X. X had X from where X when the X. The assessment was X, X, and X. X worked as a X. X could do the duties of X, could do X only if available. X remained X and X after injury. X needed an X and treatment after the X was completed. X was started on X. X and X of the X dated X were X for any X. X dated X was also X for any significant X. X of the X dated X was X.

Treatment to date included X, X, X, X. In a peer review report dated X, X, MD denied the request for X. Rationale: "X is not medically necessary, As noted in ODG's X, repeat X should be X only to assess X when X, Here, there is no record of the claimant's having had X between the date of the request X and the date of a X. It is unclear why a X was ordered, it is unclear whether the requesting provider is or is not aware that the claimant had X on X. There was no mention, moreover, of the requesting provider's having being expressed dissatisfaction with the quality of that prior study, therefore, X is not medically necessary." A peer review report was completed by X, MD, on X stating, "The request for X is not medically necessary. In this case, the claimant was assessed by provider on X for X. Per provider notes, the claimant informed X that X had previously X and X for the X; however, the provider did not understand that the claimant had also had an X done on X. The provider ordered an X at the X visit. Repeat X are only recommended by ODG guidelines for X. As the claimant has X, there is no medical necessity for a X. Therefore, the request for X is not medically necessary."

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

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. In a peer review report dated X, X, MD denied the request for X. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no documentation of a significant change in the patient's clinical presentation since X was performed on X which showed X. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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

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

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

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL