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An Independent Review Organization
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Notice of Independent Review Decision

IRO REVIEWER REPORT

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 who was injured on X. The mechanism of injury was X. X stated X. X was able to X but experienced X. The diagnosis was X. According to a X note dated X by X, X, X was status-post X injury to the X. The X showed some X with continued X and X. X reported X on the X. On examination, X and X were X. X was able to complete X with a X. X was limited by X. X of the X on X was X, X was X. X was recommended to continue treatment. X of the X dated X showed no definite X but possibly X. Later X of X indicated there was X. Treatment to date included X. Per a utilization review adverse determination letter dated X, X, MD denied the

request for X of X for the X at X as requested by Dr. X. Rationale: “The ODG recommends up to X over X for X. While the documentation indicates gains in X, the total completed to date is not noted. This information is necessary for consideration of the request. No exceptional factors are noted. Therefore, the request for X for the X is denied.” Per a reconsideration review dated X by X, MD, the request for X for the X at X were denied. Rationale: “The Official Disability Guidelines recommend X. The patient was previously treated with X and reported X in the X. X on X was X, X was X, X with the X and X was X. However, the requested X are X and X the guideline recommendation. There were no exceptional factors noted that would warrant exceeding the guideline recommendation. There was also no indication a X was X. As such, the request for APPEAL X for the X is non-certified.”

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

There is insufficient information to support a change in determination, and the previous non-certifications are upheld. It appears that the patient has completed X to date. The request for X would exceed guidelines. When treatment X and/or number of X exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of X documented. The patient has X and should be X and X with an X.

Based on the clinical information provided, the request for X. (X) is not recommended as medically necessary, and the previous denials are upheld.

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