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Notice of Independent Review Decision

Amended Letter

IRO REVIEWER REPORT

Date: X; Amended 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: X

REVIEW OUTCOME: X

INFORMATION PROVIDED TO THE IRO FOR REVIEW: X

PATIENT CLINICAL HISTORY [SUMMARY]:
X is a X who sustained an injury on X while X. X was diagnosed by X or X. X was seen by X, MD on X for X. X stated that X really X from X. The X did X, but other than that X continued to have X and X from time to time. X also experienced X. On examination, there was X, X over the X. X and X were X. X had X. Dr. X recommended proceeding with X with X and X as X all kinds of X. An X of the X dated X was X. X of the X dated X were X. Treatment to date included X. Per an Adverse Determination letter dated X, the request for X was denied by X, MD. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There were X in the most recent office visit dated X, pertinent to the X as there was no quantifiable X presented in the X records. Moreover, there was no documentation of X with X. Also, X with X. In addition, X and X could not be clearly established in the X submitted as there were no X submitted in the X. Also, there was no clear evidence of X and X to support X. Clarification is needed regarding the request and how it might affect the patient's X." Per a Utilization Review Decision letter dated X, the prior denial was upheld by X, MD. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There was still no clear evidence of X with an X. Also, objective evidence of X from X was not fully established as there were X documented in the X submitted. Moreover, X and X were not established to support the need for X. As such, the request remains unwarranted."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The ODG recommends X prior to X unless X are met for other associated X diagnoses. The ODG recommends X following a X with X and X. The provided documentation indicates the worker had X and X approximately X from injury despite X. It is documented that the worker had X from the X. The X revealed X and X and X. X and an X were X. Given the nonspecific symptoms, lack of benefit with the X indicating that the X is not the X, and lack of X on X and X, the proposed X is not supported.

Based on the available information, the X is not medically necessary.

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