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An Independent Review Organization
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Notice of Independent Review Decision

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 when X. X sustained X. The diagnosis was X. On X, X visited X, MD for a follow-up of the X. X had been diagnosed with X. X had done X with no X. This actually made X symptoms X, and X was now having X. X did show X and X. On examination of the X, there was X and a X test. The assessment was X. X was planned. An MRI of the X dated X, showed X involving the X. An X dated X was X and showed X and X in the X. Findings were consistent with X and X. X study was performed using X to X. The X demonstrated a X than X. This confirmed X in the X. Treatment to date included X, X and X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale:

“According to the Official Disability Guidelines, the request for X is not supported. The records provided for the review did not support that the X,X. Given that the patient's injury was X, X did not meet the guideline criteria for X. Moreover, the recent clinical note dated X did not include a comprehensive examination of the patient's X to determine the extent of X. Therefore, the medical necessity of the request cannot be established. As such, the request for X is non-certified. The Official Disability Guidelines recommends X for X. While the patient may benefit from X as a means of conservative treatment for the X, the physician did not specify if this was for X or for X. Furthermore, given that all requested services had not been authorized, a modified approval cannot be given at this time. As such, the request for X is non-certified. The Official Disability Guidelines recommends X for treating X, especially at X, X, or in combination with other X treatments. While it was noted that the patient was found to X based upon X testing from X, authorization cannot be given at this time has not all requested services have been approved nor was there a peer-to-peer discussion completed authorizing a modified approval for this treatment. As such, the request for X is non-certified.” Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “A peer discussion occurred, and the case details were reviewed. The requested X is not medically necessary and appropriate as the cited guidelines require a X prior to X. Therefore, the requested X is denied.”

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

The provided documentation X has X approximately X despite X, X, X and X. X made the X pain X. The X examination demonstrates X and X. An MRI of the X showed X. The provider has recommended treatment to include X. The X request has been denied twice as there has not been X. While there has not been a X to satisfy the ODG criteria for X, there has been extensive conservative treatment with X,X,X and X. Additionally, given the evidence of X on MRI, X is not expected without X to X. As such, deviation from the guidelines is advised.

Based on the available information, X is 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