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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

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 who was injured on X after X. The diagnosis was X.

Per a letter dated X by X, MD, X had a consult with X. X had a X. Some X was used to X. This had occurred after X. On X, they did a X. X of X. X was X. X did have some X. They believed the X. Another X was administered where X. X did go X. X had increased X. By X, there was some X. X examination was within X. There was a discussion about how difficult the X. The plan was to go ahead and schedule a X. X talked about a X. The plan was to put X. In an addendum note dated X, Dr X documented that because X. Per an addendum note dated X, Dr. X noted that X had a X. Unfortunately, there had been some X. Looking at the X. X did have an X. Generally,X. So, it X. X did get some X. It seemed to be a X.

An X of the X dated X demonstrated X. X was recommended. X was recommended. There were X. There was X. X was noted. There was X. There was X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X. Rationale: “X: Based on the provided documentation, X was diagnosed with X. X is being recommended for a X. The last X status. There is no documentation of X response to the X. There is also X. Therefore, medical necessity X. As such, this request is X. 2.X: Although there is mention that a X. Therefore, this request is X. 3.X: As the requested X. Therefore, this request is X. 4.X: As the requested X. Therefore, this request is X. 5. X Testing: X. As the requested X. Therefore, this request is X.”

Per a reconsideration review adverse determination letter dated X by X, the request for X: X.X. Rationale: “1.X : As per ODG X.X : (a)X - (b). Subjective Clinical Findings: Documentation of current significant . Objective Clinical Findings: (a)X. (a) X (documenting the significant X). OR (b) X (documenting X. (b) X. A peer conversation occurred in this case. X who sustained an injury from a X. X underwent a X. There was a X. On the X dated examination, X had persistent X. Physical examination revealed X. X treatment in the form of X, X. The provider stated there was X. However, X. In addition, there are X. This request X. Therefore, the X. 2. Repeat X: As per ODG, not recommended for X. Understudy for X. There is X. No X reports with a detailed X. It was stated a X; however, there is X. In addition, X typically supported. Therefore, the X. 3.X: The request is X. 4.X: The request is X. 5. X Testing:X.”

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

The requested a X. The treating provider has X. The last peer review occurred on X. At that time, X. The BMI was reported to be X. In addition,

there were limited X. No new information has been provided which would support the X. The guidelines X. Based on review of the records provided the request for X.

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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ 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

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

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

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