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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. X was at X and was X in what was X. They had placed X for X to be able to X; however, it did X and caused X resulting in X and X. The diagnosis was X and X, and X of the X .X was evaluated by X, DPM on X. X presented with a X. X was X. X continued to have X and X. X had been X with X. X stated pain was X in X. X rated pain at X. X related X, X, X along the X and X with X and X. On examination, X condition was located on the X. X sign was X with X and X. X located at X were well X. X revealed X and X. X of the X, X and X was noted. X was X. There was pain to X of the X, X of the X, and X noted. X and pain at the X was noted. X of the X showed X with X. There was an X into the X area. The

assessment was X, X and X; X, X for X with X; X, subsequent encounter for X; X and X, X; and X, X. X had X due to X caused by the X and X. X had displaced X into the X causing X. There remained a X. Due to continue pain and X, X would require X and X to treat the X related conditions. The plan was to submit for authorization and schedule X as soon as possible. On X, X was seen by Dr. X. X related pain more X, X, X, X along the X and X. X continued to X and pain along the X. Pain was rated at X. Prior treatments for ongoing symptoms were X, X, X, X, and X. X to the X relieved some of the X. X continued to have X and X and X. On examination, X test was X. The symptoms of X were X with the X and X in X and X. Findings were X. Other findings had remained unchanged from the prior visit. The established assessment was maintained. X with X / X and X was indicated to X. X may continue to X at this time until X were authorized. Dr. X evaluated X on X for X ongoing complaints. X continued to complain of X, X and X. X had X. X stated X was unable to X, X since the injury. X stated pain was X and to the X. X stated X had been X; however, pain had become X where X could X. The request for X and X had been denied. X examination and assessment remained unchanged from the prior visits. X may return to X with the following X: X: Must use X, X, and X and X. X continued to have significant pain caused by the X and X. X had signs and symptoms of X caused by the X that was X into the X and X. X examination did show signs of X. The X also caused X. The X was X and X with X. X was indicated and pending further consideration. X and X were prescribed .A X of the X dated X showed X of the X and X. No X was present at the time. There was X and X, likely due to X. X, X, and X change were seen. Treatment to date included X, X, X, X, X, X, X, X, X, X, X, X, X, X, and X. Per a utilization review adverse determination letter dated X by X, DPM, the request for X, X and X, X, X was denied. Rationale: “Regarding the request for X, X, X, X, according to the Official Disability Guidelines, indications for X or X include that the claimant has X with X, X, X, or other X, along with X. There should be subjective clinical findings of X with X and X and X, Objectively, there should be X or X and / or X. X should confirm X to include a X, X, and X or X. Pertaining to X, the guidelines state that symptoms most have X consisting of pain / X / X to the X. X should have included X and X / X along with X such as X and X. X exam findings should include X testing and X. There should be X testing for X, X other causes including X and / or X or X confirming X or X of X within the X. The information provided for the review did not support that the claimant X to all X to include a X with documented evidence of X a X of the X. Additionally, results of

the X were not provided for the review to rule out other causes of symptoms. Based upon these findings, the current requests cannot be authorized. As such, the requests for X, X, X, X was non-certified."Per a reconsideration review dated X by X, DPM, the request for X, X and X, X, X was denied. Rationale: "After careful review, it's noted that medical necessity has not been established. There has been no additional documentation submitted that meets the criteria. In addition, there was not a successful peer-to peer. My recommendation is to non- certify the request for X, X, X, X. This denial is based on X documentation received. Recommend non-certification for this appeal request." X, X and X, X, X is not medically necessary and non certified

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

Per a reconsideration review dated X by X, DPM, the request for X, X and X, X, X was denied. Rationale: "After careful review, it's noted that medical necessity has not been established. There has been no additional documentation submitted that meets the criteria. In addition, there was not a successful peer-to peer. My recommendation is to non- certify the request for X, X, X, X. This denial is based on insufficient supporting documentation received. Recommend non-certification for this appeal request." X, X and X, X, X is not medically necessary and non certified

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