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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned Disagree

☐ Partially Overturned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. The biomechanics of the injury was not available in the provided records. The diagnosis was X (brachial plexus disorders). There were X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "ODG provides criteria for X. In the affected upper extremity, all of the following must be found, X. In the affected upper extremity, all of the following X. Imaging findings must confirm X. In this case, the provider notes a diagnosis of neurogenic TOS. There is no documentation of X. There is no evidence of X correlating with the noted diagnosis of neurogenic TOS. Moreover, there is no current imaging confirming X. Given these noted factors, the medical necessity of this request is not established. Recommendation is to deny X. "Per an appeal / reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "In review of the clinical findings, the claimant was assessed with X. The claimant's symptoms had not improved with surgery performed in X. The records did not include prior treatment records to support the claimant had failed at least X months of nonoperative measures. X records were included for review. No X were included for review to support the diagnosis of neurogenic X as recommended by ODG. Given these issues which do not meet guideline recommendations, I cannot recommend certification for the request. "Based on the submitted medical records, the requested procedure is not medically necessary. The medical records do not demonstrate that the patient has X. In addition, X have been provided. In addition, there are X which demonstrate the presence of X. As such, the guidelines have not been met. 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:

Based on the submitted medical records, the requested procedure is not medically necessary. The medical records do not demonstrate that the patient has

completed at X. In addition, X have been provided. In addition, there are no X which demonstrate the presence of X. As such, the guidelines have not been met. X is not medically necessary and non certified

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