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Notice of Independent Review Decision

DATE OF REVIEW: X
Date of Amended Decision: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:

☒ Upheld (Agree)
☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

Previously on X, a physician review considered a request for X. The claimant was noted to have a history of X. The reviewer noted that the claimant's physical therapist previously documented that the claimant has met all job requirements other than unilateral carrying which required an improvement and carrying up to X pounds. A rationale was not provided as to why X. Therefore, the X was considered to be not medically necessary.

On X, Dr. X submitted an appeal letter. Dr. X discussed that the claimant's pain level was X and could spike to X. Dr. X noted that the claimant is a X, and the majority of X job requires bending, squatting, carrying, and lifting. Dr. X opined that the intensity of X.

On X, a physician review again considered a request for X. The reviewer noted that there

was no documentation of a X. Therefore, given lack of documentation, the request for X was not certified.

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

Per ODG references, the requested “X” for the patient are not medically necessary.
As noted in multiple prior physician reviews, this claimant X. There is no established basis as to why X. Concerns noted in two prior reviews have not been addressed at this time. Therefore, the request remains not medically necessary and should be noncertified.

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 KNOWLEDGE BASE

☐ AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES