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Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: X; Amendment 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

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X worked as an X. X had a work-related injury when X X right X. The diagnosis was right X stiffness, open displaced comminuted fracture of shaft of right humerus with routine healing, and right X stiffness. On X, X, OT evaluated X for occupational therapy visit / progress. X stated that X had been having increased pain in X. X stated it was X. X had continued X. X stated X had observed movement in X. X stated that X continued to have inability to X. X had made progress with X. The passive range of motion of X. After the injury, X had undergone X. X had undergone right X on X. X also had right posterior X. X had undergoing occupational therapy in X and X. X was last seen on X prior to X and hospital admission on X. X had undergone X on X and X and X was discharged home on X. X had X right upper X. X had trace movement of right X. X stated that X had been having X. X pain level in the right upper X. X had improvement in right X. X was independent with a X. X had X in right upper X. X had slow progress in right X. X was independent with a progressive X. X had improved X was noted. Right X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, DO the request for X was denied. Rationale: “There is no documentation of benefit with X. The individual has X. There is no documented follow up with X treating X. As such the medical necessity of the requested treatment is not established. Per a reconsideration / utilization review adverse determination letter dated X, the request for X is denied by X, MD. Rationale: “In this case, it is noted that the individual has X. However, it is unclear how many sessions have been attended to date. A medical report dated X states X has attended X. This greatly exceeds the allowed number of sessions for this condition per guidelines, especially given the lack of documentation regarding objective functional gains as a result of previous sessions. As such, the medical necessity of the request is not established. Per a notice of adverse determination dated X , the request for X was denied by X, MD. Rationale: “X , ODG allow X. When treatment duration and / or number of visits exceeds the guideline recommendation, exceptional factors should be noted. Patients should be formally assessed after a “X ” to see if the patient is moving in a X. In this case, the claimant is X. The claimant underwent X of right X. Claim

review indicates that the claimant had X. Objective findings reveal limited X in the right X. The claimant is X. The X provider indicates that since beginning X, the claimant has not shown a X. The X indicates that the claimant X. Considering the nature of the injury including the complex injury with X. The medical necessity of X. As there is X, the medical necessity of the X is not established. Non-certification is recommended." Partially certified: X. The documentation provided indicates that the injured worker initially underwent X right X on X. They subsequently X. The worker has X. As of X they were independent with a X. They had X. The provider documented that there is X from prior visits. There is a current request for X. While guidelines have been exceeded, the injured worker has undergone X. However, there are not exceptional factors to X. As such, a partial certification is recommended for X. The X.

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

The ODG recommends up to X. The documentation provided indicates that the injured worker X right X on X. They subsequently underwent X. The worker has X. As of X they were independent with X. They had X. The provider documented that there is X from prior visits. There is a current request for X. While guidelines have been exceeded, the injured worker has undergone X. However, there are not exceptional factors to support more than X. As such, a partial certification is recommended for X. The X.

Partially Overturned

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)**