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IRO Certificate No: X

Notice of Workers' Compensation Independent Review Decision

X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
X
INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]: This case involves a X. The mechanism of injury was detailed as a X. The patient was diagnosed with strain of thoracic spine and thoracic sprain. The comorbidity of the patient is documented as age. The previous treatments of the patient included activity modification, physical therapy, medications, and rest.

On X, the patient was seen for an evaluation related to mid back pain. The exam findings of the thoracic spine revealed X. There was X. Thoracic flexion range of motion provoked pain. The provider recommended X. The patient was to work with restrictions. The patient was to follow-up in X weeks.

On X, it was noted that the request for X was denied. The clinical documentation did not provide any data to indicate the presence of a X. Additionally, it was documented that X.

On X, the provider requested reconsideration for X. The patient was X. The patient had undergone X. The treatments had X. The provider

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recommended X. On X, the patient presented for an evaluation related to ongoing thoracic spine pain. The physical exam findings of thoracic spine noted X. Thoracic X. The patient was to complete the approved X. The patient was to be referred to a specialist regarding the thoracic spine. On X, a request for X was denied as there was no evidence of X. A request was noted for X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The Official Disability Guidelines (ODG) states that magnetic resonance imaging is recommended for X is preferred. X is recommended for X. It is also recommended for X.

A prior request for X was denied as there was X. In this case, the patient had ongoing complaints of X. The provider recommended X. However, the documentation did not support that the patient had X on exam such as with X as medically necessary. As such, the X is not medically necessary. The prior determination is upheld.

SOURCE OF REVIEW CRITERIA:

☐ 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

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Accordance with Accepted Medical Standards

☐ Mercy Center Consensus Conference Guidelines

☐ Milliman Care Guidelines

☒ ODG- Official Disability Guidelines & Treatment Guidelines

☐ Presley 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 (Provide a Description)

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

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: X