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Notice of Independent Review Decision

Amendment X

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. No office visit note or imaging results were available in the provided records. Per a utilization review adverse determination letter dated X by X, MD, the request for X non-certified. Rationale for X: “Official Disability Guidelines recommend physical therapy for knee conditions. On X, the claimant presented for a physical therapy evaluation. X complains of pain in the neck and right knee. X sustained a X due and a subsequent knee Injury. X wears a cervical collar. Cervical palpation showed X. X was within X. Right knee examination showed a X. X test. Pain reported in X. MRI of the left knee showed X. Guidelines recommend physical therapy for the treatment of knee pain. In this case, the requested number of visits exceeds guideline recommendations. X visits are certifiable as this is what the guidelines would allow for the claimant's diagnosis. However, partial certification is not allowed without an agreement from the requesting provider. As such, the requested X is non-certified.” Per a reconsideration review adverse determination letter dated X by X, DO the request for reconsideration of X was non-certified. Rationale for physical therapy for the cervical spine: “the proposed treatment consisting of reconsideration for X is not appropriate and medically necessary for this diagnosis and clinical findings. The Official Disability Guidelines states that physical therapy is recommended for X. The prior request was denied as it exceeded guideline recommendations. In this case, the claimant endorsed neck pain and bilateral knee pain. A recommendation was made for X. However, the X continue to exceed guideline recommendations for initial treatment. As such, the X is non-certified.” Rationale for physical therapy for the right knee: “the proposed

treatment consisting of reconsideration for X is not appropriate and medically necessary for this diagnosis and clinical findings. The Official Disability Guidelines states that X. The prior request was denied as it exceeded guideline recommendations. In this case, claimant endorsed neck pain and bilateral knee pain. A recommendation was made for X. However, the X. As such, X is non-certified." The requested X is not medically necessary. The guidelines do support physical therapy for sprains/strains of the cervical spine and right knee. However, the requested number of sessions exceeds the guidelines. According to the records, a modification to the request cannot be made without a peer review with the treating provider. This has not occurred. Therefore, the current request exceeds the recommended guidelines. The prior non-certifications are upheld. 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:

The requested X is not medically necessary. The guidelines do support physical therapy for sprains/strains of the cervical spine and right knee. However, the requested X exceeds the guidelines. According to the records, a modification to the request cannot be made without a peer review with the treating provider. This has not occurred. Therefore, the current request exceeds the recommended guidelines. The prior non-certifications are upheld. 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