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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 Overtuned 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 sustained a X. After X injury X subsequently developed an X. The diagnosis was X left X of left, X of left X .On X, X had an initial pain evaluation by X, DO for chief complaint of X left X, X, X. X was involved in a X. Ultimately, X developed swelling, sensitivity and burning sensations, had been on a sundry of medication management including X. Due to the persistent nature of X pain, X did undergo treatment for suspected X. A X finger of the left X was also noted. X admitted to X. A pain-related X. X had moderate risk under X. X X was negative for X. X X was checked to be satisfactory as X had been treated with X. X pain was anywhere from X. Examination revealed a X of X left compared to X right X of more than X. There were X. X was warm on the left on the X. X had pain with X. X in the neck and X back area was also noted. X was preserved. X were down going. No X was elicited. Romberg testing was X. No X was elicited. The assessment included X left X. Once adequate medical management had been achieved, interventional pain care in the form of X was recommended On X, X was seen by X, MD for follow up of X ongoing complaints. X continued reporting pain and lack of strength in the left X. The pain was constant from the X. X described X pain and X. Examination was unremarkable. The assessment included X of left X, X, X of left X, X of left X. X was recommended to return for follow-up after X visit with Dr. X on X. X was seen by Dr. X on X for X ongoing complaints. X continued with severe left X, X. X was not getting better. X had a X. Furthermore, there were no other disorders that caused this disorder. The ODG specifically stated that aggressive and repetitive treatment in the form of X was indicated. The denial of this care was X. Continued active X were recommended. X was increased to X. X was continued. X was increased to X. X was asked to take pictures as X was showing signs of X. X would be sent to a higher level of expertise for re-evaluation. Dr. X opined that X should be considered both diagnostic and therapeutic in this disorder. An X of the left X dated X showed X. X of the left X. X of the left X dated X demonstrated X of the left X corresponding to area of X. No X were observed. Left X X revealed soft tissue X of the left X. The presence of X. No X or X was noted. Treatment to date included X. Per a utilization review adverse determination letter dated X by X ,

MD, the request for X was denied. Rationale: “The records provided did not document evidence of the fulfillment of the X. Based on the information provided, the request is not shown to be supported by the ODG nor otherwise medically necessary. The request for X is non-certified. “Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “In this case, there is no record X. Furthermore, physical examination findings X. X findings are limited to temperature X. The pain was noted on the range of motion evaluation, but the range of motion was not noted to be X. The request for X is not medically necessary. “Thoroughly reviewed provided records including provider documentation and peer reviews. Provider clearly lists out how the patient meets criteria for X. X also indicated given delicate location of X. Requested procedure is warranted based on X visit documentation that further clarifies any reservations that peer reviews may have had. X is medically necessary and certified

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

Thoroughly reviewed provided records including provider documentation and peer reviews.Provider clearly lists out how the patient meets criteria for X. Requested procedure is warranted based on X visit documentation that further clarifies any reservations that peer reviews may have had. X is medically necessary and certified

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)**