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Notice of Independent Review Decision

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

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 sustained an injury on X. X was X; X lifted a X and X l to X left X and pain. The diagnoses included unspecified X. On X, X, MD examined X for left X pain. After the injury, X went home and the following day, X felt a sharp pain in left X. X underwent X. The pain was described as X. X pain and symptoms were interfering with X daily activities and X work. The X pain was associated with X. The pain was X. Left X examination revealed X. X test, X test, and drop X tests were X. There was X over the left X. X were noted. X intervention was recommended due to X persistent pain and symptoms that were interfering with X daily activities and X work. X had X. On X, X was evaluated by X, MD for a follow-up of left X. X stated left X, X was painful. X had to X. X was working full day. X rated X pain X. On examination, movements were painful with X. The X test was X. There was X noted in the X. Per an independent medical evaluation by X, MD on X, X reported that X had to position X in a way to avoid pain when X. X was working. On physical examination of the left X, there was X. Movements were painful with X. X remained on X. X was working, but careful not to X. X restrictions included the X". On examination of the left X, X had a X on the left X. X had a painful X. X test caused pain and the X test showed also pain, along the X. X did not have quite the X on the X as X did on the X. It was opined that X had not reached maximum medical improvement. It was noted that X would benefit from X. X needed X. Following the X, X would be placed at maximum medical improvement, X. An X of the left X on X showed X. Treatment to date included medications X. Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request is Non-certified. The records submitted for review would not support the requested procedures as reasonable or necessary. The claimant had reported ongoing left X pain despite X. However, the current evaluation did not detail any specific X exam findings concerning for a X. The prior X, X report also did not define a X. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the X. As the X is not indicated, there would be no requirement for a X. Further, the records did not detail a X requests." Per the utilization review by X, MD on X, the request for X tests X was non-certified. Rationale: "Based on the clinical information submitted

for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request is non-certified. The prior X, X report dated X also did not define a X. Given these issues which do not meet guideline recommendations, the request for left X, X is not supported. As the X is not indicated, there would be no requirement for X. No additional or new information was received that would alter the facts of this case. No exceptional factors were identified to overturn the previous determination dated X."The requested X is not medically necessary. The X does not demonstrate the presence of a X. In addition, there is no examination which demonstrates a X. The X is not supported by appropriate evidence-based guidelines and standard medical care. As the surgical request is not medically necessary, the associated/X request are not needed. X are 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 X does not demonstrate the presence of a X. In addition, there is no examination which demonstrates a X. The X is not supported by appropriate evidence-based guidelines and standard medical care. As the X request is not medically necessary, the X request are not needed. X are 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**
- 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)**