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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 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 did not remember the impact, noted X was healthy. X remembered looking up with people over X; thought X lost consciousness. The exact mechanism of injury could not be deciphered. The assessment included X right X; X of unspecified site of left X; X of other specified X and X, right X; pain in right X; pain in right X; pain in right X X of back wall of thorax; nausea; dizziness; pain in right X; post trauma headache; X. X had a physical therapy evaluation and treatment by X, DC on X for complaints related to the bilateral X, bilateral X, and X back. The visit note was largely illegible. With regard to the X, pain in the bilateral X was described as right X. Pain was aggravated by X. Bilateral X pain was aggravated by X. X back pain was described as X; aggravated by getting X. On examination, X was X. X were noted on the X. X and X tests were X on the right X. The assessment included X of right X; X of unspecified site of left X; strain of other specified X at X, right X; pain in right X; pain in right X; pain in right X; X of back wall of thorax; nausea; dizziness; pain in right X; post trauma headache; X. The handwritten note was poorly scanned and largely illegible. X was treated with electrical stimulation to right X and cold pack to X and right X. X continued to attend physical therapy sessions from X. On X, X noted some slight improvement. X was able to move better and went to walk on X. X noted X in the right X and was not X. X had difficulty with activities of X. Examination showed right was better. X noted pain with X. X had difficulty with X. X was recommended therapy X. Treatment modalities included therapeutic exercise and X release. The handwritten note was poorly scanned and largely illegible. Per the X note, X noted X still had significant pain and noted difficulty with X. X noted pain in the X back was worse with X.

There was pain in the left X. The headaches were about the same as before. The right X was reviewed. Per a Treatment Plan note by Dr. X, X presented for right X, bilateral X pain, bilateral X and right X pain. X was recommended X therapy X. Treatment modalities would include X release and X exercise. An X of the right X dated X showed X involving the X of the right X extending to the X of the X. X and X were noted, involving the X. There was a X involving the X left X. Treatment to date included physical therapy. Per a utilization review dated X, the request for X for left X, multiple X injury, right X, right X, right X, right X, right X, and X back area (X and X) X, from X was denied by X, DC as not medically necessary or appropriate. The rationale or peer review report was not available in the provided medical records. Per a reconsideration review dated X, the appeal request for X for the left X, multiple X injury, right X, right X, right X, right X, right X, and X back area (X) X was denied by X, DC. The rationale or peer review report was not available in the provided medical records Based on the clinical information provided, the request for X for left X, multiple X injury, right X, right X, right X, right X, right X and X back area (X) X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review dated X, the request for X for left X, multiple X injury, right X, right X, right X, right X, right X, and upper back area(X) X, from X was denied by X, DC as not medically necessary or appropriate. The rationale or peer review report was not available in the provided medical records. Per a reconsideration review dated X, the appeal request for X for the left X, multiple X injury, right X, right X , right X, right X, right X, and upper back area (X) X was denied by X, DC. The rationale or peer review report was not available in the provided medical records. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that this patient has X therapy visits to date. The request for X would continue to exceed guidelines. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no

exceptional factors of delayed recovery documented. There is a lack of documentation of ongoing significant and sustained improvement. The patient has completed sufficient X therapy and should be capable of continuing to improve X, self directed home exercise program. The X therapy for left X, multiple X injury, right X, right X, right X, right X, right X and X Back area (X) 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:

Per a reconsideration review dated X, the appeal request for X for the left X, multiple X injury, right X, right X, right, right X, right X, and X back area (X) X was denied by X, DC. The rationale or peer review report was not available in the provided medical records. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that this patient has completed X visits to date. The request for x. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. There is a lack of documentation of ongoing significant and sustained improvement. The patient has completed sufficient X and should be capable of continuing to x. The X for x knee, multiple x injury, right X, right X, right X, right X, right X and X back area (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)**