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IRO Certificate No: X

**Notice of Workers' Compensation**
**Independent Review Decision**

**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 regarding X.

The records indicate the patient had a history of X. The patient had X. After X, X daily X were not as severe. X reported X improvement in X. When the patient was seen on X, X had a body mass index (BMI) of 41 with stable vital signs. X was taking multiple medications to include X. Listed diagnoses included anxiety, chronic back pain, depression, headaches/migraines, and vertigo. The report noted that the use of X was effective, but X was still having X. X claimed X caused side effects cognitively and was therefore X. Records indicated that an in-office electroencephalogram (EEG) was X. On examination, the patient endorsed X. X had X. X had minimal X. The treatment plan was for the patient to continue X. X would be rendered to the X.
The patient was also recommended for X.

Request reconsideration was submitted on X stating that the patient needed X.

On X, the request for X was determined to be not medically necessary. The available records did not clearly show that the frequency of the claimant's X. The total number of X was also not specified in the records provided for the review.

Prior to the initial treatment with X. This review pertains to X.

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

1) **Are the requested services, X medically necessary for this patient?**

**Answer:** No. The requested services, X are not medically necessary for this patient.

The Official Disability Guidelines states that X.

The documentation provided for review did not support that the prior use of X. As of X, the patient was still having X. It was therefore determined that X did not satisfy the criteria for X. In addition, the submitted X. There was no indication as to why the patient needed to go to the X. This type of care should be rendered on an as-needed basis for emergent situations. Based on review of the provided documentation, the requested X are not medically necessary for this patient.

**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

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- □ 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
- □ 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 |