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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 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. Per a utilization review adverse determination letter dated X by X, MD, the requests for diagnostic X were denied. Rationale for denial of diagnostic X: "Per the ODG X. A diagnostic X is the preferred procedure to determine X. No more than one set of diagnostic X should be performed prior to X. Clinical presentation should be consistent with X. The claimant had X. There was X. However, there was no documentation of significant X. As such, the request for diagnostic X is not medically necessary." Rationale for denial of X: "Per the ODG by X is recommended for carefully selected patients with proven X. Conflicting evidence, primarily observational, has challenged procedural efficacy, which is not without complication risks, Criteria includes the X. There should be a diagnostic X. There should be no more than X. Should not be repeated within X. The claimant had X. There was X. However, there was no documentation of the X. As such, the request for X is not medically necessary. "Per a reconsideration review adverse determination letter dated X by X, DO, the requests for X were denied. Rationale for denial of diagnostic X: "Official Disability Guidelines recommends X. On X, the claimant was seen for low back pain. Exam showed X. Treatment includes X. As such, the request for RECON Diagnostic X is non-certified." Rationale for denial of X: "Official Disability Guidelines recommends X. On X, the claimant was seen for low back pain. Exam showed X. Treatment includes X. No new information was provided that would substantiate overturning the previous non-certification. As such, the request for X non-certified. "Based on the medical documentation, the requested procedure is not medically

necessary. The records reflect X. No new information has been provided which would overturn the previous denials. Diagnostic 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:

Based on the medical documentation, the requested procedure is not medically necessary. The records reflect X. No new information has been provided which would overturn the previous denials. Diagnostic 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