Independent Resolutions Inc.
An Independent Review Organization
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Notice of Independent Review Decision

Amendment

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:

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured on X. X was involved in a X. The diagnosis was X of sacral region, unstageable; X of sacral region, X of left hip, chronic X of hip, X, and chronic pain. On X, X, MD evaluated X inpatient for sacral X. X was sent from a nursing home for sacral X. They wanted X to be admitted. X had a history of X. X was evaluated at the bedside. X was doing well in the morning, with no acute complaints. X pain was controlled on the ongoing regimen. Discussed about

discontinuing the X because X was not prescribed this medication long term prior to admission. On examination, X blood pressure was 96/59 mmHg. X was lying in bed in no acute distress. Neck had evidence of X. Abdominal examination revealed X. Per the assessment, X had X. X presented to emergency department from skilled nursing facility (SNF) upon doctor request for admission for suspicion of X. A CT scan showed X; however, there were no plans for intervention. X was stable at the time, non septic in appearance with X. X was on X until EOT X. X was placed on X and ID re-evaluation done on X, determined that there was no other alternative X regimens for treatment of this X with X and oral X. X ESR was greater than 100 and CRP was 165.A CT scan of abdomen and pelvis dated X revealed X. Treatment to date included ED visit, surgical intervention X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale for X: “Records show that the patient has a X and X. The notes also show that cultures grew multi-drug-resistant pseudomonas. There aren't too many choices for treatment of this type of infection, although medical necessity is established, the request cannot be certified as the second request is noncertified. Therefore, the request for X is non-certified” Rationale for inpatient admission: “There are no clinical notes provided from X to X. Medical necessity is not established. Therefore, the request for X is noncertified.” Per a reconsideration / utilization review adverse determination letter dated X, X, MD, the request for X was denied. Rationale for X: “On review, the available data submitted and carefully reviewed on X do not demonstrate evidence-based peer-reviewed clinical studies that prove that the requested services are medical necessities at this time. The medical record does not confirm that the requested service is medically necessary for the evaluation and treatment of this patient's work-related injury of X. Therefore, the appeal request for X is upheld and is non-certified.” Rationale for inpatient admission: “On review, the available data submitted and carefully reviewed on X do not demonstrate evidence-based peer-reviewed clinical studies that prove that the requested services are medical necessities at this time. The medical record does not confirm that this service was necessary for treating the work-related injury. Therefore, the appeal request for X is upheld and is non-certified.” Patient with advanced resistant infection for which needs newer X such as X to properly treat infection. Regardless of disposition or

where patient receives this antibiotic, in order for wound to be properly treated, use of this X is medically necessary. X is medically necessary and certified

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Patient with advanced resistant infection for which needs newer X such as X to properly treat infection. Regardless of disposition or where patient receives this X, in order for wound to be properly treated, use of this X is medically necessary. 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

☐ 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

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☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL