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Notice of Independent Review Decision

Amendment X

IRO REVIEWER REPORT

X**:** ; Amendment

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 is a X who was injured on X. Per a utilization review adverse determination letter dated X by X, DC, the request for X was denied. Rationale: "Official Disability Guidelines recommends X. On X, the claimant complains of X. Lumbar exam showed X. There is no documentation of return-to-work goal or job plan noted. As such, the request for X is non-certified." Per a letter of adverse determination after reconsideration notice, dated X by X, DC, the request for reconsideration of X was denied. Rationale: "The proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Official Disability Guidelines conditionally recommends X. Guidelines indicate a X when an X. Physical exam noted X. Treatments have included X. Records do not indicate that the claimant is not a candidate for further interventions. I spoke with the provider and informed X of the decision regarding the requested treatment. Therefore, the request of X, is non-certified."Throughly reviewed provided records including peer reviews. Agree with peer reviews, that per their cited guidelines (ODG), patient does not meet criteria for X. Though has already tried X, patient still needs other criteria such as: appropriate screening, diagnostic interview with mental health provider, any documentation of other biopsychosocial issues, detailed description of job demands and how X works in to meeting those functional demands. 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:

Agree with peer reviews, that per their cited guidelines (ODG), patient does not meet criteria for X. Though has already tried X , patient still needs other criteria such as:X. 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