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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 the request for X was denied by X, MD. Rationale: “Regarding X, ODG recommends either X. Criteria for surgery include at least X months of X. Most X are temporary and will subside, followed by long periods of remission. Subjective symptoms should include X. There should be objective findings including X. In this case, there is no evidence of moderate to severe X. There is no evidence of X. As this claimant did not meet the guideline criteria for X, the request for X is not medically necessary. The recommendation is to deny this request.” Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “This is an appeal of a previous denial which noted "there is X. There is no evidence of X." The records did not X. No formal physical therapy records were included for review. Further, the records did not include a formal MRI report for the X. Given these issues which do not meet guideline recommendations, I cannot recommend certification for the request. I spoke with Dr. X on X. Per our discussion, X indicated that the claimant had X. Additional records would be submitted to support the X request. At the time of submission, an additional 21 pages of records were received for review that included a radiograph report for the left shoulder dated X which were X. The X left shoulder MRI report only noted X. As such, the determination remains unchanged.” The requested X is not medically necessary. According to the medical records, there is no evidence of X. In addition, no records have been provided which demonstrate that the patient has attempted an appropriate course of conservative treatment. No new information has been provided which would overturn the previous denials. X not medically necessary and non certified.

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

The requested X is not medically necessary. According to the medical records,

there is no evidence of X. In addition, no records have been provided which demonstrate that the patient has attempted an appropriate course of conservative treatment. No new information has been provided which would overturn the previous denials. X 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