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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 after a work-related X. The diagnosis was history of above-knee amputation (AKA), right; history of below-knee amputation (BKA), left; abnormality of gait; weight loss; fitting and adjustment of prosthetic device. X, MD evaluated X on X. X presented for X. X was interested in pursuing a X for X AK side now that X had lost weight and had a desire to be more mobile with X. X presented with an amputation on X. X was status post work-X. X had a X that X wore less than X hours per day due to problems with it. X was experiencing X. X had modifications made to the X. On telemedicine examination, X was noted to be X. The amputation level on the right was above knee (transfemoral) and on the left was below knee (transtibial). The shape of limb was conical AKA and cylindrical BKA irregularly shaped. The skin incisions were well healed with no drainage. A new prescription was provided for a X. X was to do X. X was to use a X. Treatment to date included X. Per a utilization review adverse determination letter dated X, and a peer review report dated X, the request for X was denied by X, MD. Rationale: "Per Official Disability Guidelines, Knee and Leg, Online Version (X are 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. Prior adverse determinations have been made. The rationale for the adverse determinations were due to a lack of a X. Based on the submitted medical records, a X. No new information has been provided which would overturn the previous denials. X are 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