Independent Medical Reviews LLC
17304 Preston Road, Suite 800 | Dallas, Texas 75252
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

DATE OF REVIEW: 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:

☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

This injury dates to X. Diagnoses include paraplegia from an acute spinal cord infarction. A prior physician review considered a X. The reviewer noted that based on a telephone call with the provider, the claimant was using a X. The claimant has completed over X. The reviewer noted that an indication for X was not apparent.

On X, the claimant was seen in X. The claimant was noted to have a X. The claimant was noted to have symptoms including X. Ongoing goals included return to X.
On X, Dr. X submitted a narrative letter stating that the claimant has the ability to X.
Dr. X noted the claimant needs to X. Dr. X recommended that the claimant would benefit from X.

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

Per ODG references, the requested "X" for the patient are not medically necessary.

This claimant has attended at least X. This injury is more than X. In this timeframe, more than X after an injury, additional functionally meaningful progress such as that suggested in the treatment plan is

unlikely to occur. Moreover, while such improvement may occur, if it does occur, then it could occur spontaneously or through a continued independent rehabilitation program. There is no basis to conclude that additional X at this time is more likely to lead to the stated goals than a X.

As such, the prior denial should be upheld. The current request is not medically necessary and should be noncertified.

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 KNOWLEDGE BASE
- ☐ AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

FOCUSED GUIDELINES