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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. The date of injury, mechanism of injury, or the diagnosis was not available in the provided medical records. Please note, no office visits or imaging were available in the provided medical records, only 2 utilization reviews and 2 peer reviews. Per a utilization review adverse determination letter dated X and a peer review dated X, the request for X was denied by X, DO. Rationale for denial of X: "The request for X is not medically necessary. Due to the nature of this medication, weaning may be indicated and could be considered. Based on the documentation provided, the requested X is not recommended at this time. Though the claimant has a history of X, there was no documentation of any objective functional improvement on the current medication regimen. Given the lack of provided evidence, it is not recommended at this time. Therefore, the request for X is not medically necessary. Due to the nature of this medication, weaning may be indicated and could be considered." Rationale for denial of X: "The request for X is not medically necessary. It was noted that the claimant has X, and the current medication regimen does provide the claimant with improvement in X. Given that this is a X case, and without provider modification, the request is not recommended at this time. Therefore, the request for X is not medically necessary. "Per a reconsideration review adverse determination letter and an appeal review dated X, the request for X was denied by X, MD. Rationale for denial of X: "No medical records were provided for review. There is insufficient information to determine the medical necessity of the request. Therefore, the request for X is upheld and non-certified."

Rationale for denial of X: “ODG does not address the request for X. Per peer-reviewed literature, "X seems to be as effective as or less effective than X, but more effective than other drugs used in the treatment of attacks. The X is more effective than X, but less effective than X. Additional reports suggest that X is particularly useful in X not satisfactorily responding to X, in those with X.” However, no medical records were provided for review. There is insufficient information to determine the medical necessity of the request. Therefore, the request for X and non-certified. “Thoroughly reviewed provided records including peer reviews. Note that no documentation from requesting provider was provided thus unable to ascertain current or prior treatment plan. While the patient could potentially benefit from X, it is unclear if the medication requested has been helpful to patient in the past. Given request for X, would expect patient to have perhaps trialed other abortive medications prior to consideration of this medication. However, no records provided to demonstrate any prior or current treatment plan, subjective complaints/improvement in pain scores, or objective finding 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:

Note that no documentation from the requesting provider was provided thus unable to ascertain current or prior treatment plan. While the patient could potentially benefit from X, it is unclear if the medication requested has been helpful to patient in the past. Given request for X, would expect patient to have perhaps trialed other abortive medications prior to consideration of this medication. However, no records provided to demonstrate any prior or current treatment plan, subjective complaints/improvement in pain scores, or objective finding 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