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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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. X was in X. X was able to X. X initially had X. Not long after, X reported issues with X. The diagnoses were posttraumatic stress disorder and anxiety disorder. X was seen by X, MD on X for complaints of X. X had been started on X. X was referred to X. Over the weeks, X had started noticing X. X had been prescribed X. X had quit X job. X continued to take X. X did have X. X presented for a follow-up of X. X stated overall the symptoms had increased. X had X. X was X. X had X. On examination, X was alert and oriented to time, place and person. X was X. X was X. X was noted. X appeared X. X were clear to X. X was X. Due to X, an X was requested to evaluate for X. X was placed on restricted duty. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was not medically necessary or appropriate. Rationale: “The individual is a X with a date of injury X, who is currently working with restricted duty. According to a visit dated X, the individual reports X. X is unsure if this is related to X. Patient did have a X in X, but has not received the results. X was X on examination. Official disability guidelines conditionally recommend X. X is not recommended for: X. In this case, the individual was involved in a X. X has been diagnosed with anxiety and PTSD. There are X. As such, the medical necessity of the requested treatment is not established and is denied. “Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X did not meet medical necessity guidelines. Rationale: “The claimant is a X who sustained an injury on X. The mechanism of injury was X. This is an appeal request for a X. The claimant had been followed-up for X. The claimant had reported “X.” There were no previous diagnostic studies included for review. The X evaluation noted continuing X. The physical exam was X. No other X were noted. X were X. The request was previously denied due to X. The clinical records did X. X were noted. At

this point, it was unclear how the requested X. Without X is recommended. “The claimant had continued to describe complaints of X. The claimant had recently reported X. The most recent evaluation did note some X but the claimant was X. The records did not detail any current X. There is no indication that the X. Therefore, it is this reviewer’s opinion that medical necessity for the request is not established and the previous denials remain upheld. 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:

The claimant had continued to describe complaints of X. The claimant had recently reported X. The most recent evaluation did note some X. The records did not detail any current X. There is no indication that the X. Therefore, it is this reviewer’s opinion that medical necessity for the request is not established and the previous denials remain upheld. 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