

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]:

The patient is a X with listed date of original injury of X. There is no description of the injury but from prior reviews and X work status form it appears that X had a X. There is no objective information available with imaging or physical exam related to the X but per reports and X diagnoses X has X. The clinical notes suggest that the current request for making X. The clarification that the patient only has a X outside the house and is not currently using them inside X house is noted in that this counters one reason for prior denial.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Per ODG references the requested "X" is not medically necessary. By the subjective description of the patient's disability, it does seem that X would meet criteria to qualify for full-time use of a X. The issue is that there are no objective findings, such as imaging of the X or any physical examination findings, presented in the available documentation to support that X has a X. All the current documentation of the condition is based on patient reports, either to X physician as documented in the office notes, or directly in the patient's own notes. If objective imaging of X that relates it to X original injury and objective physical examination findings that suggest X can be provided, then the request for making the X. Without this information then the prior decision not to approve the current request is 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 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