proper since the beginning.
po box 519
schertz, tx 78154
p: 800.292.3051
f: 888.972.7053

IRO Certificate No: X

Notice of Workers' Compensation Independent Review Decision

Date of Notice: X Amended Date: X

TX IRO Case #: **X**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a X.

On X a Progress Note was completed by X. The provider indicated the patient presented with a complaint of X. The patient had a primary medical history of X. The provider stated the patient was seen in the clinic on X and at that time the patient reported increased pain in X upper extremities after the X. The patient reported prior settings were controlling X pain well. Based on this discussion the X. On X the patient's X called stating the patient was confused, delirious, nauseous with suspected pinpoint pupils. The

provider recommended the patient present to the clinic for X. The provider indicated the X. The provider indicated X. On physical exam the patient was noted to be saying unusual things. There were no abnormal physical exam findings noted. The provider indicated the X. The provider also prescribed X.

On X a X Report was completed. The report indicated the patient required a X. The note also documented X. The medication noted was X. Documentation indicates the X.

On X a Progress Note was completed by X. The provider indicated the patient presented for follow-up with chronic pain after undergoing a X. The provider stated pain X was rated X. The provider stated the procedure provided X. The provider also stated the patient complained of right arm pain that is worse in the evening. The provider stated the patient's average pain was X and maximum pain was X. Current treatments included X. The provider stated treatment and medication provided relief of X as well as improved function with activities of daily living. There were no abnormal physical exam findings noted. The provider stated the patient had an X. The patient was provided X.

On X a Notice of Determination was completed by X, MD. Documentation indicated the request was not authorized as guidelines indicate there must be documentation of failure of at least X. The determination also indicated if treatment was determined to be medically necessary the efficacy and continued need for the intervention and refills should be

periodically reassessed and documented. The reviewer determined in the case under review, the injured worker's current status was unknown and there was no clear objective evidence of benefit from past use to include functional improvement. Review indicated medical necessity of the request was not clearly demonstrated and a clarification was not obtained. Reviewer also indicated X.

On X a Notice of Determination was completed by X, MD. Documentation indicated the request for reconsideration of a previous noncertification was reviewed. The determination indicated the request did not meet the established criteria for medical necessity stating the most recent available treatment note had no reported subjective or objective findings to support the request. Documentation stated the recent efficacy of the medication with documented level of pain improvement and functional abilities was not clearly evaluated. The reviewer also indicated the most recent note was dated X.

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

The Official Disability Guidelines indicate if treatment is determined to be medically necessary, as with all other treatment modalities, the efficacy and continued need for this intervention and X should be periodically reassessed and documented. ACOEM Guidelines state X are not

recommended for treatment of chronic nonmalignant pain conditions.

Evidenced based literature indicates it is important to continue urgent pain management procedures in a safe way, to include X. Literature also states for the management of noncancer-related pain, the use of X remains a later therapeutic option, reserved after other treatment options and interventions have failed.

On X the patient presented after undergoing emergency X with reports of confusion after X adjustments were performed. The treating provider X by decreasing the dose X. On X the patient was seen for follow-up after undergoing a X. The treating provider indicated X. The treating provider indicated treatment and medication management improved function with activities of daily living. There were no abnormal physical exam findings noted. The treating provider indicated the patient's X was currently working well for pain and that at the time of examination X was not necessary. On X a notice of determination indicated the medical records submitted for review requesting X did not support the request. The treating provider indicated medical records to document the efficacy and continued need for the intervention and X. On X a second notice of determination was completed indicating the request for X was denied as the records submitted for review reported no subjective or objective findings to support the request.

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The medical records submitted for review did support documentation to include X efficacy and the continued need for intervention and X. In addition, the documentation did include subjective/objective findings to support the request for X. The medical record submitted for review supported evidence-based guideline recommendations for periodic reassessment and documentation required for ongoing X. As such, the request for X (X) for X between X to X is considered medically necessary and the prior determinations are overturned.

SOURCE OF REVIEW CRITERIA:

☒ 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

☐ Presley 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 (Provide a Description)

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

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: X