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IRO Certificate #X

Notice of Independent Review Decision

DATE OF REVIEW: X

IRO CASE NO. 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)

Overtaken (Disagree) X

Partially Overtaken (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY SUMMARY

This is a X year old patient with history of work injury due to X in December of X which was followed by a fall at work in X. X was terminated from X job in X. X was seen by Dr. X on X and he ordered an MRI of the cervical and lumbar spine. X was referred to Dr. X with diagnoses of radiculopathy in the lumbar region with lumbar disc disruption at X. Other diagnoses include right cervical radiculopathy, myofascial pain syndrome with cervicogenic headache of the cervical, midthoracic, and lumbar regions, moderate reactive depression, insomnia in chronic neuropathic pain state after sustained lifting over X hours. MRI of the lumbar spine on X showed X. On X an X. Request for X dated X was for X. A request for X was placed on X. This was denied due to X. Appeal was also denied due to no new information. There is documentation from X by Dr. X that X has had more than X pain relief and improved function, affect, and sleep. There is also documentation from Dr. X on X shortly after the first

PATIENT CLINICAL HISTORY SUMMARY (continuation)

X that X is able to be more functional and active and has a better gait. There is also documented order for X.

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

Opinion: X disagree with the benefit company's decision to deny the requested service.

X disagree with the decision to deny requested service due to needing more current documentation of significant functional and pain improvement following X in X and

documented X order following that first X and documentation of X pain relief during X follow up visit after the X.

Rationale:

This review pertains to the need for a X. ODG recommend X. A X would require documentation that X. These criteria appear to have been met based on documentation available to me for review.

The requested service: X” is medically necessary for the patient and totally appropriate as X meets criteria for X.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 &
EXPERTISE IN ACCORDANCE WITH ACCEPTED
MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE
GUIDELINES

MILLIMAN CARE GUIDELINES

**ODG-OFFICIAL DISABILITY GUIDELINES &
TREATMENT GUIDELINES X**

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY
VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE
DESCRIPTION)