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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 Overtuned (Agree in part/Disagree in part)

☐ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X.

Please note, no medical records other than X utilization reviews were provided in the available records.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied as not medically necessary or appropriate. Rationale: "The Official Disability Guidelines recommends X. In this case, the claimant presents for repeat referral to X. On the examination, right upper extremity strength is X, right lower extremity strength is X, left upper extremity strength is X, and left lower extremity strength is X. Increased X was noted. The guideline states that X is recommended as a first-line option for X. However, there is no documentation of completion of a training program, X with the device over a X-month period. As such, the request X is non-certified."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, DO. It was determined that the request still did not meet medical necessity guidelines. Rationale: "The Official Disability Guidelines recommend X. Per letter of appeal dated X, the claimant has X. The claimant has been involved in X. The claimant is making progress and has set new goals to improve their independence

and will require more complicated devices that are specifically targeted localized areas of the body. The devices are a means to prevent the claimant from compromising their gait, which can ultimately cause pain and deterioration of joints. On X, the claimant was seen for an office visit and reported they were never contacted for X. The claimant has a X. The claimant requires X. On the examination, the right upper and lower extremity strength was X in the left upper and lower extremity strength was X. There was increased X. The claimant was in a wheelchair. The claimant has not received therapies yet. This request was previously reviewed and denied as the guideline states that X is recommended as a first-line option for X. However, there is no documentation of completion of a training program, X. In this case, there is documentation that the claimant has not had therapies. There is no evidence that the claimant can transfer independently and stand for at least X minutes and can bear weight on upper and lower extremities to maintain an upright posture independently as recommended per the guidelines. In a peer-to-peer call with X, MD at X on X at X PM CST, the provider stated that the claimant had X ordered X and has not completed the sessions yet. The doctor agrees to hold on to equipment requests until the claimant completes therapies. As such, the appeal request for X is noncertified."

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient X meets criteria for use of X requested based on cited

guidelines. The patient has X. Thus request for X are medically necessary and certified.

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

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient meets criteria for use of X requested based on cited guidelines. The patient has X. Thus request for X are medically necessary and certified.

Overturned

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
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ 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
- ☐ 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)**