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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 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 X. The diagnosis was localized traumatic cataract of the right eye.

On X, X, MD evaluated X for a consultation for traumatic cataract of right eye. X stated that X had been X. X denied noticing those issues in the left eye, but stated it was hard to tell due to the issue in the right eye / double vision due to the injury of right eye. The right eye cataract was progressing more than the left eye due to X prior trauma.

On X, X, MD evaluated X for a follow-up. X stated X had new glasses and had seen well with the new glasses. X denied double vision. On base eye examination of right eye, visual acuity was X (Dist cc). Intraocular pressure was X for the right eye. X was using glasses for correction. X was stable and controlled with prisms. Slit lamp examination of right eye revealed status X. There was X. Lens had X. Right eye fundus examination revealed X.

On X, Macular optical coherence tomography was completed indicating X.

Treatment to date included X.

Per a peer review and utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Per Official Disability Guidelines. Eye Chapter, Updated (Online Versions X), Cataract

and Complex Cataract Surgery, “X." Per case literature review, “A X.” In this case, the claimant presents for cataract. The claimant has been X. The physical examination revealed X. In this case, no medical necessity established for X. Therefore, this request is not medically necessary and is not certified.”

Per a peer review dated X, X, MD, the appeal request for X was denied. Rationale: “Per Official Disability Guidelines Eye (Updated X), X, “Conditionally Recommended. Recommended as an option; X :X. X.” In this case, the claimant had complaints of cataract. The claimant reported of X. The claimant reported of double vision. The examination showed X. However, the corrected vision was better than X in the right eye. Therefore, this request is not medically necessary and is not certified.”

Per a utilization review adverse determination letter dated X, an appeal request for X was upheld by physician advisor.

Patient was noted of having a X. Patient reports X. X had a X. Corrected Visual acuity of the right eye was noted to be X on X and X on X. Given the subjective symptoms, the clinical documentation of X cataract, and interference of daily activities as patient is having to close X right eye, to see more clearly, X SHOULD BE approved for this case. There is no indication in the records for this to be a X. X is medically necessary and certified

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

Patient was noted of having a X. Patient reports X. X had a X. Corrected Visual acuity of the right eye was noted to be X on X and X on X. Given

the subjective symptoms, the clinical documentation of X cataract, and interference of daily activities as patient is having to close X right eye, to see more clearly, X SHOULD BE approved for this case. There is no indication in the records for this to be a X. X is medically necessary and certified

Overturned

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

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

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE