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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]:

According to the medical records provided, the claimant X, was involved in a motor vehicle accident on X. According to emergency department notes from that date the then X was involved in a X. X was part of a X. The claimant denied loss of consciousness. X reported facial contusions and abrasions, neck pain, right low back pain, left cervical pain, left knee abrasion and right ankle pain. X presented to the emergency department through X. X endorsed hitting X head but states X had no loss of consciousness. X was an X.

Additional medical documentation from the date of X reflects that the claimant was treated with X.

A prescription dated X written by X, ARNP, reflects a diagnosis of post-traumatic stress disorder and motor vehicle collision initial encounter with referrals to psychiatry, evaluate and treat.

An undated psychological evaluation: Goals/plans/justification form by X, PhD, was included. This form appears to request X.

A X non-certification letter by X, PhD, was included. This non-certified letter determined that the request for X. On X, an appeal response to the denial letter was submitted by X, LPC-S. The appeal stated the requested services are medically appropriate to help improve the overall quality of life with the request that the case be reopened for appeal.

A X non-certification letter by X, MD, determined that the request for X be non-certified.

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.In reviewing all the medical evidence, clinical finding and documentation associated with these requested services for X, it is my determination that the requested services remain unsupported and are not medically necessary in this claimant's case. According to the clinical evidence contained within the provided medical records, the requested services are not supported as medically necessary by the Official Disability Guidelines. The evidence does not support this testing as there is X. There is a lack of clinical evidence that supports the requested services as necessary beyond what could be gathered through X. Given that there is no clear documentation of symptoms associated with post-traumatic stress disorder that require testing beyond the determined condition, the requested service does not meet guideline criteria. Therefore, the request for X should remain non-certified in this examiner's opinion.

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