Independent Medical Reviews LLC
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Notice of Independent Review Decision

Amended and sent on X

DATE OF REVIEW: X

Date of Amended Decision: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 provided clinical findings, the claimant, X, had an injury which resulted in a broken foot. No actual medical records were provided associated with medical services for that member's condition. There is an ambulatory referral to X order form completed on X which identified the referral details to reflect a diagnosis of multiple closed fractures of metatarsal bone of right foot by X. There is a comment on the form that note worker comprehension, stress and depression, related to WC injury of foot. It was noted in the various documentation that the member's date of injury was X. The member's health plan denied, it was requested by X, PhD, on a preauthorization request for X. That request was determined non-certified. It was

determined that noncertification was due to having X. This denial was appealed on a X appeal letter by X, LPCS, stating that the member does meet the medical necessity criteria for the requested X. It has been noted that there has been a major issue in delay with getting medical records from the primary office and that a referral was initiated from observations of the claimant's mental health decline and conversations with X about home and life behaviors. The request for overturning the denial cited support by the official disability guidelines for mental illness and stress under diagnostic testing, psychological.

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 for the patient.
It is the determination and outcome of this psychiatric review that the requested services of X is not supported as medically necessary for treatment of the member's condition. The provided clinical evidence does not demonstrate or document adequate clinical findings to support the requested service. It is stated that the claimant had a diagnosis of multiple closed fractures of the metatarsal bone of the right foot following an injury that occurred on X. Aside from that, the only comments were noted that the member is experiencing stress and depression related to the injury. This request does not meet the official disability

guidelines for X. These guidelines identify one of the requirements in that the proposed X can help answer a question that X. The comment of the member experiencing stress is of non-clinical determination. The comment that the member is experiencing depression can be effectively determined by less intensive and expensive means. Identifying an individual with a diagnosis of depression can be conducted through a X. Identifying the member with the possibility of depression does not meet the medical necessity guidelines X. Therefore, the requested service is determined not medically necessary for this member in this situation.

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