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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 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]:

The claimant is a X with date of injury of X. The provider has submitted a X. Claimant was injured due to X. Diagnoses were post-concussion syndrome, chronic post-traumatic headache, migraine with aura and without status migrainosus, occipital neuralgia of the right side, cervicogenic headache, cervicalgia, vestibular dysfunction after traumatic injury, photophobia, convergence insufficiency, decreased functional activity tolerance, cognitive dysfunction, cerebral/cortical visual impairment, attention deficit hyperactivity disorder, post-traumatic stress disorder, anxiety, depression. The work status was undisclosed. Previous treatments included X. According to office visit on X, the claimant's overall condition has remained stable, although persistent symptoms were present. These included headache and episodic migraines with visual aura. There was X. The X had not been effective.

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

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition: X. ODG Head (updated X), X; X.

Studies on the use of X. X The mechanism of action is not understood, nor is there a standardized method of the use of this X. A recent study has shown that X. (X) The X.

Per ODG, X. Studies on the X. The claimant has X. In addition, the guidelines do not overwhelmingly support these X. Per evidence-based guidelines, and the records submitted, this request for X is not medically necessary.

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**

☐ **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 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 (PROVIDE A DESCRIPTION)**