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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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. The diagnosis was fusion of spine, thoracic region (X).

Per a X, dated X, X presented to X for the diagnosis of fusion of spine, thoracic region (X). X asked if it was X. The following X Questionnaires were completed on X, and revealed: X Score: X. X Score: X. Work Status: not working. Ability to work: was off work. Per the assessment, X tolerated the plan of care well that day. X showed X. X showed X. X still needed X. X would benefit from X.

No office visits were available for review.

Per a utilization review / Notice of Adverse Determination dated X, the request for X was denied by X, DO. Rationale: "Regarding requested X, as stated in the guidelines, X is recommended and given X. The Official Disability Guideline indicates that for X. In this case, claimant was seen regarding injury to the X. Claimant had X. The X. Although the claimant has X, the request is not medically necessary for this claimant who had recently had X."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "The current diagnosis is fusion of spine, thoracic region. On X, the claimant had a follow-up clinical visit with no documented complaints. X were performed during the visit The assessment noted X. The X recommended X. This request was previously non-certified due to X. Per claimant information, the claimant underwent X. They have already X. The Official Disability Guidelines recommend X. X is recommended when there is X. The claimant is X. This request X dated on X was previously non-certified due to X.

They had X. The assessment noted X. The X recommended X. However, there were X. They also X. Thus, the request for X is non-certified."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. There is X to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that the patient X. The Official Disability Guidelines support up to X. This patient has X. The request for X. When X should be noted. There are X documented. Therefore, the request for X is not medically necessary in accordance with current evidence-based guidelines and the decision is upheld.

Upheld.

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