# Independent Review Organization (IRO) Notice of Decision Template – Preauthorization Exemption Rescission

# Notice of Independent Review Decision

**Send to:**

Texas Department of Insurance

Managed Care Quality Assurance Office (MCQA), MC LH-MCQA

**Email:** [IRODecisions@tdi.texas.gov](mailto:IRODecisions@tdi.texas.gov)

**Note: only send the IRO decision to the issuer and TDI (Don’t send to the patient(s) and provider).**

**[For the issuer, provide:**

**Name of party and US mail address or (As applicable)**

**Name of party and other means of transmission]**

**[Date notice sent]**

RE: IRO Case number **[TDI Assigned Number]**

Provider’s National Provider Identifier (NPI):

**[Name of IRO]** has been certified, certification number **[IRO Cert #]**, by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to the IRO for independent review in accordance with the Texas Insurance Code and applicable regulations.

The IRO has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, the IRO reviewed the medical records and documentation provided to the IRO by involved parties.

This case was reviewed by a **[Specialty of Reviewing Physician or Health Care Provider]**. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the patient(s), the patient’s insurance carrier, the utilization review agent (URA), any of the treating physicians or health care providers who provided care to the patient, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of **[Name of IRO]** I certify that:

1. There is no known conflict between the reviewer, the IRO and / or any officer employee of the IRO with any person or entity that is a party to the dispute.
2. A copy of this IRO decision was sent to the parties via U.S. Postal Service or otherwise transmitted in the manner indicated above on **[Date]**.

Sincerely,

**[Name of IRO Representative]**

**[Title]**

**[Date notice sent to the parties (Issuer and TDI only)]**

**[IRO Case #]**

## Description of the health care service



## Description of the qualifications for each physician or other health care provider who reviewed the decision



## Review outcome

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Provide a description of the review outcome that clearly states whether **medical necessity exists** for the health care service.



## Additional information provided to the IRO for review, if applicable (in addition to information provided on TDI form LHL011)



If a second random sample of claims was requested, list claim numbers:



Medical Records (check if yes)

## Analysis and explanation of the decision include clinical basis, findings, and conclusions used to support the decision



## 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 Judgment, Clinical Experience, and Expertise in Accordance with Accepted Medical Standards

Mercy Center Consensus Conference Guidelines

Milliman Care Guidelines

ODG- Official Disability Guidelines & Treatment Guidelines

Presley 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)