

IRO NOTICE OF DECISION TEMPLATE – WC

[INDEPENDENT REVIEW ORGANIZATION LETTERHEAD]

Notice of Independent Review Decision

SENT TO: Texas Department of Insurance
 Managed Care Quality Assurance Office (MCQA) MC 103-5A
 E-mail IRODecisions@tdi.texas.gov

[FOR EACH INVOLVED PARTY PROVIDE:

NAME OF PARTY AND US MAIL ADDRESS or (as applicable)

NAME OF PARTY AND OTHER MEANS of TRANSMISSION]

[Date notice sent to all parties]:

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

Name: **[of Injured Employee]**

Coverage Type:

Workers' Compensation Health Care Network

Workers' Compensation (non-network) if applicable, decision must include specific basis for divergence from TDI/DWC policies or guidelines

Type of Review:

Preauthorization Review

Concurrent Review

Retrospective Review

Prevailing party (if applicable)

Requestor

Carrier

[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, the Texas Labor 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 injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, 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 all of the parties via U.S. Postal Service or otherwise transmitted in the manner indicated above on **[DATE]**; and
3. A health care provider licensed to practice in Texas performed the independent review.

Right to Appeal

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:

Chief Clerk of Proceedings
Texas Department of Insurance, Division of Workers' Compensation
P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512-804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.

Sincerely,

[NAME OF IRO REPRESENTATIVE]

[TITLE]

IRO REVIEWER REPORT

[Date notice sent to all parties]:

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

A 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)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether **medical necessity exists** for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:**PATIENT CLINICAL HISTORY [SUMMARY]:****ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:****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 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)