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IRO REVIEWER REPORT

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:
This physician has over X years of experience in X.

REVIEW OUTCOME:

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

X

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

PATIENT CLINICAL HISTORY [SUMMARY]:

X: Progress Evaluation, Plan of Care, and Daily Progress Note by X, X. X: Primary Functional Limitation: Patient is X. Second Functional Imitation: Patient is X. Third Functional Limitation: Patient is X. Fourth Functional Limitation: Patient is X. Assessment: Patient presents today with X. Patient has X. Patient X. As a result, patient X. Patient will X.

X: Progress Evaluation, Plan of Care, and Daily Progress Note by X, X. X: Primary Functional Limitation: Patient is X. Second Functional Imitation: Patient is X. Third Functional Limitation: Patient is X. Fourth Functional Limitation: Patient is X. Assessment: Patient presents today with X. Patient has X. Patient continues X. Patient has X. Patient will X.

X: Progress Evaluation, Plan of Care, and Daily Progress Note by X, X. Progress Evaluation, Plan of Care, and Daily Progress Note by X, X. X: Primary Functional Limitation: Patient is X. Second Functional Imitation: Patient is X. Third Functional Limitation: Patient is X. Fourth Functional Limitation: Patient is X. Assessment: Patient continues X. Patient still X. Patient will X.

X: UR performed by X, MD. Rationale for Denial: A case of a X. X has completed several sections of X Per provided medical records. X condition X. Provided medical records shows the patient X. Provided medical records X. Guidelines recommend X. This case has already completed X. The provided medical records X. Recommend non-certification for X.

X: UR performed by X, MD. Rationale for Denial: Regarding the requested X, the ODG recommends up to X. The provided documentation indicated the injured worker X. There is no evidence the injured worker X. Based on the available information and ODG recommendation, X is not medically necessary.

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

Denial of an X. Therefore, X visits are 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 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)