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IRO REVIEWER REPORT

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:

The Reviewer is a Board-Certified 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]:
The claimant is a X.

X: Imaging report
X interpreted by X, DO. Prior X. X. X. X.

X: Progress note by X, MD. The claimant was being seen for ongoing complaints of X. It was detailed that the claimant had X. PE of the X reported X. There was X.

X: UR performed by X, MD. Rationale for denial: The claimant was recommended for the X. However, the documentation provided did not indicate that the patient had a diagnosis of the X. There are X.

X: UR performed by X, DO. Rationale for denial: Noting the date of injury, the X. The finding on the MRI do not support X. As such, this is not warranted.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The request for X is denied.

The patient sustained a X. X underwent an X. X continues to have pain in the X, rated X. X does not have X. On examination, X has X. X has some degree of X.

The recent MRI demonstrates X. X also has a X. The treating provider has recommended a X.

Based on the records reviewed, it is unclear whether an X is the source of this patient's complaints. X has X. There is no documentation of X on physical examination. It is unclear whether the patient has any pain at the X. Additionally, the record does not indicate whether the patient's X. Based on these factors, I am not convinced that the proposed X.

The request for X is found to be not medically necessary, based on the records reviewed.

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)