Vanguard MedReview, Inc.
101 Ranch Hand Lane
Aledo, TX 76008
P 817-751-1632
F 817-632-2619

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:
This case was reviewed by a Board-Certified X with experience X with over X years of experience.

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: MRI X. **Impression:** 1. X. There is X.
X: Office Note by X, PAC
X: UR performed by X, MD. **Rationale for Denial:** This is a case of a X patient who sustained an injury on X after a X. Per MRI of the X by X, MD dated X revealed X. There were X. Per office visit report by X PA-C dated X, the patient presented with complained of X. It X. There was X. The pain X. X tried and X. It was noted that X. On X examination, the X. On X examination, there was X. There was X. On the X examination, there was X. There were X. The X was X and X were X. There were X on the X. The X was X. However, there were X in this visit. X-ray of the X dated X showed X. X-ray of the X dated X revealed X. MRI of the X dated X demonstrated X. At X, there was a X. There was a X. However, there was X submitted to support the information. An assessment revealed a X. The treatment plan included X. X was advised to follow up in X month. Medications included X. Prior treatment included X. The current request is for X. Per evidence-based guidelines, X are recommended as a short-term treatment for X. An X is recommended for X. In this case, the patient presented with complaints of X. It X. On X examination, X. On the X examination, there was X. A request for X was made. Although it was noted that X tried and X. There were X notes submitted for verification. There was also X submitted for comparison to X recent office visit dated X to validate the X. Furthermore, there were X on the recent visit to fully established patient's current condition. Lastly, there was X. Pending this information, thus the request is not fully supported at this time.

X: UR performed by X, MD. **Rationale for Denial:** Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced above, this request is non-certified. This X injured X on X when X involved in a X. The reported condition is considered X. X are done but X. X for X yielded minimal improvement.

There is no documentation that the following remedies, which generally constitute X, were completed: There was X that the patient was X. The review of systems was as follows: X: X. A magnetic resonance imaging (MRI) of the X on X documented the following: X. A request for X was made. The request is NOT certified because the following criteria were X: the patient does NOT have a X; there is no clear documentation that the patient has had X, which has included as a X; the request does NOT include a X; the request does NOT include a X, which includes X. A successful peer-to-peer conversation has taken place and no additional clinical information is expected to be provided.

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

Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced above, this request is non-certified. There is no documentation that the following remedies, which generally constitute X, were completed: There was X that the patient was X. The patient does NOT have a X; there is no clear documentation that the patient has had X, which has included as a X; the request does NOT include a X; the request does NOT include a X, which includes X. For these reasons, X
is not medically necessary and should be denied.

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
- [x] MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- [ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- [ ] MILLIMAN CARE GUIDELINES
- [x] 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)