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.

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 interpreted by X, MD. **Impression:** 1. X. There is X. 2. X. 3. X. 4. X. 5. X.

X: Office Visit by X, MD. **Assessment/Plan:** X. At this point given X.

X: Encounter Summary by X, MD. **Assessment/Plan:** Last visit we did an X. X reports that provided X. Since then X has had a X.

X: Surgery Request by X, MD. X now had a X.

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. The clinical findings presented were X. In addition, clarification is needed as to when the patient had received a X. There were X.

X: UR performed by X, MD. **Rationale for Denial:** Based on the clinical information submitted for review and using the evidence based, peer-reviewed guidelines referenced above, this request is non-certified. There was X. Moreover, there was X. Furthermore, the patient was X to fully justify the need for this request.

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

The request for X is denied.

This patient has X. X continues to have X. X recent MRI demonstrated X. X has X. X treating provider has recommended X.

The Official Disability Guidelines (ODG) supports X. X have X which correlate with X. Patients X.

This patient has X. However, X is under the X. There are X. The X identified on MRI are X. A X should be considered prior to X.

X is not medically necessary at this point in time.

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)