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IRO REVIEWER REPORT

Date notice sent to all parties: 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:

Board Certified in X
Fellowship Trained in X
Added Qualifications 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]:

The patient was initially injured at work, sustaining a X. X was treated with X. The patient subsequently X. The final X note is dated X, in which it was recommended that the patient return to X. On X, the patient was reevaluated by Dr. X for follow-up. X exam documented X. Dr. X recommended referral for X. The progress note documented x-rays of the X that were performed on X, demonstrating X. It also documented the patient's ability to function at a X. Recommendation was made for a X. On X, the patient was evaluated by Dr. X. X performed a X examination, documenting only that there was X. No other X exam findings were noted and X referred the patient for X evaluation with X, which occurred on X. In that evaluation, the X noted that the patient's X score was "minimal" and that the Beck Anxiety Inventory score was "X." It also noted that the patient was a "X. It incorrectly documented that the patient had "X" that would lead to a "X" when, in fact, there was no documentation of such evidence based on the documentation reviewed. X were then recommended. An X was performed on X, demonstrating the patient's ability to function at a X. Initial review of the request for a X on X was accompanied by a peer-to-peer conversation with X, a X and the rationale for denial of the request was discussed. The physician reviewer noted that the "determination was agreed upon." It was also noted that X questioned whether or not a X had actually taken place when, in fact, documentation of that program has been reviewed by myself currently. On X, an appeal for reconsideration of the X was submitted with the rationale that the X "would help the patient with X." A subsequent second physician reviewer upheld the recommendation for denial of the program based upon the X

testing documented by X demonstrating X "could not be addressed by X." The reviewer also noted that there was " X.” Finally, the physician reviewer noted that there had been no evidence of the patient X.

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

In my opinion, the requested X are not reasonable, medically necessary, or supported by the Official Disability Guidelines (ODG). As pointed out by both physician reviewers, the patient's X testing demonstrated X. At most, the patient demonstrated some degree of X. Additionally, since the patient has not had any X. It is also not clear in the records provided for this review whether or not there are any X. Therefore, based on all of the above, the previous two physician reviewer recommendations for denial of X are upheld at this time, as the request is not appropriate, medically necessary, or supported by the criteria of the ODG.

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 JUDGEMENT, 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**
- ☐ **PRESSLEY 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)**