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An Independent Review Organization
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IRO REVIEWER REPORT

Date: 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: X

REVIEW OUTCOME:

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

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured in X. X had X. X was diagnosed with X. On X, X was seen by X, MD for follow-up evaluation in regard to the X. X continued to have X. X continued to complain of X. X heard a "X" sound in X that had X. X had X. X was X. On X, X had X, X, or X. X had X to X area. X had a X and X from X in the X and X at X. X was X in X. X was X in the X. X were X in the X and X. X was X on X and X on X. X could X. An MRI of the X dated X identified a X. X of the X was present. The X was X. There was X from the prior study of X. An MRI of the X and X dated X demonstrated X. This could be the X. There was X. X was noted. There were X. X x-ray dated X showed X. X were X. A X of the X was noted, most likely a X. X x-ray showed X. There was X. The remaining X appear X. X x-ray dated X demonstrated

X. There was X. The treatment to date included X. Per a utilization review by X, MD dated X, the request for the MRI of the X was noncertified. Rationale, "The condition is now X. There is a lack of X to support need for X MRI. Considering the lack of discussion of X, the request is not medically necessary." Per a utilization review by X, MD dated X, the request for the X was noncertified. Rationale, "The claimant reported X. Examination revealed X. X at X. There was X. X were X. X noted as X. An x-ray of the X revealed X.X. However, there is limited X to support need for X. Therefore, medical necessity has not been established at this time."

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

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review by X, MD dated X, the request for the X was noncertified. Rationale, "The condition is now X. There is a lack of X to support need for X. Considering the lack of discussion of X, the request is not medically necessary." Per a utilization review by X, MD dated X, the request for the X was noncertified. Rationale, "The claimant reported X. Examination revealed X. X at X. There was X. X were X. X noted as X. An x-ray of the X revealed X. X. However, there is limited X to support need for X. Therefore, medical necessity has not been established at this time." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The submitted clinical records indicate that the patient's most recent images are from X. There is X submitted for review. It is unclear if there has been a X. There is a lack of X on X examination which would require X.

Given the documentation available, the requested service(s) is considered not medically necessary and the request is upheld.

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

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL