

## **CASEREVIEW**

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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:**

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 who was injured on X. X was X to assist a X. Diagnosis: X. MRI dated X of the X. There was X. There was X. There was X. There was X. There were X and X. Per progress note dated X, the claimant had completed X. X was placed X and was X and X. X is currently X. On X examination of the X and X. On X,

X was seen for recheck of X and X. On examination, there was X but no X. It was X. There was X on the X. There was X. There was X. On examination of the X and X, there were X. There was X on the X and all X. There was X. On X, the X. The X. There was X and X. X evaluation demonstrated X. Plan: The claimant would return to work with X. The X. X for X. The restrictions were X. Treatment plan included X.

On X, MD performed a X. Rationale for Denial: Official Disability Guidelines recommends X. The documentation provided detailed that the patient had sustained an X with a X. The patient was detailed as X of the way toward meeting the goals of X job and had completed X. There was decreased X and X. It was stated that the patient was X. A request was made for X. However, this request would exceed guideline recommendations and X cannot be made without a X and X. Additionally, the documentation provided did not indicate that the patient would not be able to manage X with a X at this time. As such, the request for X is non-certified.

On X, MD performed a X. Rationale for Denial: In this case, the documents show that patient has X visits for treatment of X. The Official Disability Guidelines allow X. The request for X more visits would be in excess of guideline allowances. Medical necessity is not established.

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

Determination: Denial of an additional X visits for the X and X visits are not medically necessary.

**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)