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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]:

X performed by X, MD, X. **Rationale for Denial:** This is a case of a X patient who sustained an injury on X. The mechanism of injury was not documented. Per office note by X, MD dated X, the patient presented for X and X. On physical examination of the X, there was X increased with X and X. The sensation was noted X. According to the office visit note by X, MD dated X-, the patient presented for X that had been occurring in a X for X. Multiple X to X and X. The course had been X. The X pain was described as a X that was in the X. The pain was relieved by X. X had a history of X but required X. Per review of systems, the patient had X with X. All other systems were noted X. X was diagnosed with X. The treatment plan included X and X was to follow up in X. There was X list of current X documented on this visit. The current request is for X. Per review of related X subject patients to the risks and discomfort of a X the X, and limits the X. X is not uncommon, and X of X. In this case, the patient presented for X that had been X. X had multiple X to X and X; however, there was no X report submitted to validate the information. A request for X was made. However, the functional improvement from the continued using the X could not be fully established to warrant the need for the request as there was no clear evidence in improvement of X, documented for review. There was still no recent X assessment of the X with X such as X and X testing, and X by X presented in the recently attached medicals. Pending this, the request is not supported.

X: performed by X, MD. **X for Denial:** Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is not medically necessary. In light of this presenting issues and in the absence of pertinent extenuating circumstances that would require deviation from the guidelines, the request for appeal X is not medically necessary as the functional improvement from the continued using the X could not be fully established to warrant the need for the request as there was no clear evidence in improvement of X documented for review.

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, this request is not medically necessary. In light of this presenting issues and in the absence of pertinent extenuating circumstances that would require deviation from the guidelines, the request for appeal X is not medically necessary as the functional improvement from the continued using the X could not be fully established to warrant the need for the request as there was no clear evidence in improvement of X documented for review. Therefore, the request for Appeal X is not medically necessary and is non-certified.

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)