



Professional Associates, P. O. Box 1238, Sanger, Texas 76266
Phone: 877-738-4391 Fax: 877-738-4395

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

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.

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X-rays of the X revealed no X or X. The patient then presented to X and was assessed to have a X. X, and X were prescribed, and the patient was X. X date of injury was noted to be X. X injured X while X. X felt pain in X, and X was now having X and X. X had X that radiated to the X. X noted X had been given a X and X in the X and the X was causing some X. X was advised to stop its use. X had a history of X. X was X, which was felt to likely be due to X. X had X. X were X and X was X. In the X, there appeared to be X and X. The X also appeared X and there was X and X. The patient was then evaluated in X on X. There was X and X was X. X was recommended X. As of X and X a X, but X had X and X. X was again elevated, but X was in X. X reported X but was X in clinic. X declined an X and X was advised to have the X. As of X noted X had improved and X denied.

X had attended X since the last visit. Exam of the X was essentially unchanged. As of X noted X still had pain in the X. X was again elevated, and it was again noted this was likely due to X. X had X and X. As of X, the patient had attended X. It was felt X needed additional X a week for X. It was then noted on X that the MRI had been denied. X noted after X had X and had been consistent since that time. X had X on exam, but X and X. X was restricted. X was refilled and an MRI of the X was again recommended. X provided an adverse determination for the MRI of the X. Here it was noted the adjuster did not receive the MRI request, so it was be resent and X had been put on hold until the MRI was done. The patient still had X and was advised to find a PCP for it. Exam revealed X. X was intact and there was no X. On X provided another X for the MRI of the X. On X, the patient was now having X. X was X at that time. X had X. Exam was

unchanged. X was continued and the patient was referred out for an X. It was noted the X MRI had been denied twice.

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

The patient is a X who worked for this employer approximately X. The described mechanism of injury was X when X developed X. The patient subsequently sought care at X by X. X was diagnosed with X and X. Treatment to date has included X. The patient has been noted to have X but has somewhat of an unclear diagnosis. The only significant X finding has been X. The evidence based Official Disability Guidelines (ODG) would expect resolution of a X. The requested X MRI was non-certified on initial review by X on X. X non-certification was based on the lack of X. X non-certification was then upheld on reconsideration/appeal by X, M.D. on X. X based X opinion on the criteria as outlined by the ODG. The ODG criteria or indications for imaging/MRI scan include the following: X is required. X comminuted X or X planning may be appropriate, but X is preferred. X or X suspect X if X or X is required. X or X, X, or X. X or X, suspect X. X films show X. The request for MRI of the X does not meet any of the criteria, as outlined above, according to the evidence-based ODG. The patient has had essentially a X examination, except for some X. Therefore, the requested MRI of the X is not medically necessary, appropriate, or supported by the evidence-based ODG and the previous adverse determinations are upheld at this 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 JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- 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**