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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 with date of injury X. X sustained a X. X was X. X landed on X. X felt X. X was taken to the X emergency room and X and X, and displaced X. The diagnoses included X. X, MD evaluated X on X for X, and X. The pain was X and X. The pain was described as X and X in nature. Pain interfered with X and X with X. X had X and X. X was X and X. X had X and was X and X. X had open X. X was X. X criteria for the diagnosis of X were met. X revealed X. On X and X examination, there were X and X of X and X, and X. There was X. There was X. It was X to touch. X presented to Dr. X on X for a follow-up of X and X, which was X. X reported that X was X. X was X and X. Pain was better with X, and X. X also complained of X. Pain

was X. X reported the X and X and X. Pain was better with X. On examination, for X, there was X. The treatment to date included X. X had improved X and X. Per a Utilization Review Adverse Determination letter dated X, the request for X was denied by X, MD. Rationale "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The request exceeds guideline recommendation as guidelines indicated that required with a response of X percent." Per a Reconsideration Adverse Determination letter dated X, the request for X was noncertified by X, MD. X "There is evidence of X. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified."

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 Adverse Determination letter dated X, the request for X was denied by X, MD. X "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The request exceeds guideline recommendation as guidelines indicated that required with a response of X." Per a Reconsideration Adverse Determination letter dated X, the request for X was noncertified by X, MD. X: "X if there is evidence of X and X. There were no X findings documented for X. In addition, there are no documented evidence of lack of response to X treatment including X and X as there are no X submitted. X are not a X." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that the patient underwent prior X. X had X and X. Although there are X reports of improvement following the X, there are no X of improvement documented to establish efficacy of treatment. There are no X records submitted for review. Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the decision 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