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Notice of Independent Review Decision

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:
MD, Board Certified 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 patient is a X. The patient X. The patient was seen and X. MRI of the X. X causing X. The X appears to be X. No X. Office visit note X indicates that X. Office visit note dated X indicates that X. On X examination X. X on X. X is X on the X. The patient was recommended for X. Office visit note dated X indicates that the patient X. The X into X. X level is X. There are no significant changes in X. The

initial request for X was non-certified noting that X, “Recommended as an option in X.” In this case, there is no record of an X. There are no documented extenuating circumstances to support an X. The denial was upheld on appeal noting that there is X available for review. The claimant was last seen almost X status is unknown. The order for X did not include a recent office note. X is a X to other recommended treatment, especially X like X. There is no evidence that the claimant is X. Focusing solely on X for a X is not supported by guidelines.

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. The submitted clinical records document completion of only X. There is no updated, detailed X submitted for review. There are no specific, X goals provided. The Official Disability Guidelines note that X is recommended as an option in X. There is no documentation of any ongoing X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

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)