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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: The reviewing physician is certified by 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]:

Claimant is a X who sustained an injury on X while X was using a X. Claimant complained of X. MRI of the X showed evidence of X. Previous treatments include, X.

X: MRI X. Impression- X. X of the X, possibly due to X.

X: Clinical Note with Dr. X. Reports X is X or when combined with any X. X did not have X but now does have X. Need another MRI to X. DX: X. X-rays in office shows no X.

X: Clinical Note with Dr. X. X in response to X applied there. Current Medication is X 2. Waiting for MRI approval

X: MRI X. Impression- 1. X with X. 2. X. 3. No significant X. Post contrast images show X.

X: Clinical Note by Dr. X. X by X. X is quite well in X. On examination, X. X in response to X applied. X testing in X. X has been X has been X. X given X today. This is X. X needs X to possibly receive some relief, X has done all X can do for X.

X: Determination. Rationale- Per guidelines, X is recommended as an option for X. X is not recommended for treatment of X. There was insufficient objective evidence of exhaustion of conservative treatments as there were no X and X notes. Furthermore, there was no X or advanced imaging reports presented. Non-certified.

X: Clinical Note by Dr. X. X on X; associated with X. X was denied; Still cannot X to X. On exam, X is noted. X had X and on X stated X improvement. Today is X from X reports no X.

X: Adverse Determination by Coventry. Rationale- Objective findings presented were insufficient to fully meet the criteria for the requested X. There was no clinical evidence to suggest presence of X. Guidelines

indicated that X are the most common X. There was also inadequate findings related to X. Furthermore, objective evidence that the X had X was not completely established in the medical records submitted to consider the requested X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION: The previous adverse decision is Overturned. X at work in X. The X MRI demonstrated a X. The patient continues to have X, which X. X has completed a course of X. The patient's underlying problem is a X which is X, consistent with the X identified on MRI. X complaints and objective X findings X. It is not expected that X condition will X. Therefore, the request for X is considered medically necessary for this patient.

Recommended as an option for X. X is not recommended for treatment of X. Due to a X and significant complication risk, X should not be performed by X.

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)