



Specialty Independent Review Organization

IRO REVIEWER REPORT

AMENDED REPORT DATE: X

ORIGINAL 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 reviewer is a Medical Doctor who is board certified in X

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a X who X. X occurred while X was X. Past X was X.

The X impression documented X. The X MRI impression documented X. At X, there was X and a X. At X, there was X. At X, there was X. At X, there was X and a X.

A review of records documented that X had included X. There was no documentation of X or X, or X.

The X exam report X. The X was X. The overall X. X and X were suspended due to X. Overall, the patient demonstrated X.

The X report documented X including X. The X documented the patient had developed X. X connected to X. It was recommended that X participate in a X in order X. X should be re-evaluated for X.

The X report cited complaints of X. X was X with X. X was X. Treatment had not X. X was X. Current X included X. X exam documented X. X was X. X exam documented X. X had X with the X. X was decreased in the X. The diagnosis included X. The patient had X. X ability to X. X MRI demonstrated an X. X was X. X reported after X. The treatment plan recommended X.

The X report cited X. X was provided by X. The X had recommended X and X. X reported that X. X exam documented X. X of X. The patient had X. X had X. X exam documented X. X MRI findings were documented as above. The diagnosis included X. The patient had X. X was to X. The treatment plan recommended a X was needed to X.

Authorization was requested on X.

The X review determination indicated X, was denied. The X stated that the patient's X. Furthermore, there were insufficient objective evidence of supporting treatment with X.

Authorization was again requested on X.

The X review determination indicated that the denial of the request X, was upheld. The X stated that X. The results of this testing X.

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

The X provide specific criteria for admission to X. Criteria include X. The X should also X. Additional criteria include: There is X. X programs should be X. The X.

This patient presents X. X has X. Clinical exam findings have been X. X treatment to date X. Under consideration is a request for X. The X criteria outlined above have X. There is evidence X. There is X. The patient has been X. There is X. There is no X. Therefore, this request X, is not medically necessary.

**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)**