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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:
This case was reviewed by a Board-Certified Doctor of 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]:

X: MRI X MD, PhD. **Impression:** 1. X.

X: X performed by X, MD. **Rationale for Denial:** 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 clinical findings in the recent report were insufficient to X. Also, there was no documentation of X. Moreover, the X of X. As the current request for X is not deemed medically necessary, the X request for X are also not supported at this time.

X: Letter of medical necessity by X, MD. Patient has had X. X has tried X. X continues to X. Prolonged X and X of X condition will not X. In order to avoid this scenario, I believe it is medically necessary to proceed with X to give the X.

X: X performed by X, MD. **Rationale for Denial:** Based on the clinical information submitted for this review and using the evidence-based, X, this request is non-certified. The clinical findings in the recent report were still insufficient to X the request as there was no documentation of X. Also, there was no documentation of X. Per guidelines, it is recommended at X. Moreover, the X. There were no additional medicals noting significant objective changes in the medical records submitted to address the previous reasons for denial. Furthermore, during the X with X, the provider stated that the X. There is X. Patient has been X. On MRI there was X. The X was discussed. The patient does not fully meet the criteria per ODG guidelines. Patient has X. Therefore, all the above request is not supported. As the current request for X is not deemed medically necessary, the X request for X are also not supported at this time.

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

The request for X is denied.

The patient is X who X. X MRI demonstrates a X. X also has a X. The treating

provider has recommended X.

The X supports X. Patient should have X. X have X. They have X. The imaging studies should demonstrate a X.

Similar recommendations are made by the X. X have X. They have X.

Based on the records reviewed, it is unclear whether this patient has X. The patient should also X. The records X indicates the patient's X.

The recommended X is not medically necessary. Therefore, the request for X is not medically necessary and should be denied.

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)