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**IRO REVIEWER REPORT**

**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 is a X who was injured on X. X was X. The diagnoses were X. On X was evaluated by X, MD for the X. The pain radiated into the X. An MRI of the X. At the time, X was able to X. The pain level at the time of visit was X. The pain level at its worst was X and the pain level at best was X. The pain was described X. X with the pain. X mood was X. On examination, X. X examination revealed X. X had X. On X reported X was able to X. Pain level was X. Per X had, in fact, been prescribed X. On X, MD, evaluated X in a X. X stated that overall, the symptoms had X. Pain was rated X. X range of motion was X no X noted. X remained unchanged. X was X. X recommended continuing X and recommended follow-up with X. An MRI of the X on X, revealed that at the X. At the X, there was a X. At the X, there was a X. The X. At the X, there was an X. The treatment to date consisted of medications X with

X.  On X, the request for X. X: “This request is not supported. Although this X has complaints of X, as well X on MRI, previous X treatment has not been exhausted. The X specifically states there should be failure to improve with X. The only medications prescribed for this X. Without exhausting X, this request is not supported.”  On X, the X request for X was X. X: “Based on the clinical information provided, the X, as X is not recommended as medically necessary. The initial request was non-certified noting although this X has complaints of X, as well as X involvement on MRI, previous X has not been exhausted. The X specifically states X. The only medication prescribed to this X. Without exhausting X this request is not supported. There is insufficient information to support a change in determination, and the previous non-certification is upheld. No additional information was provided to address the issues raised by the initial denial. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.”

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

This patient has been referred for a X.  The patient’s X.  X has included X and an MRI.  The MRI shows X.  Two prior reviews question whether X.  This patient appears to have undergone X as per the medical records.  The medical records indicate that patient underwent X

The original denial is overturned. Given the documentation available, the requested service(s) is considered 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 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

X