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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: X

REVIEW OUTCOME:

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

X

PATIENT CLINICAL HISTORY [SUMMARY]:
X who was injured on X. The mechanism of injury was described as a X. X was diagnosed with X. On X, X was seen by X, DO. X had X. X was X. X noted X. There was pain in the X. On examination of the X, the X were X. X was noted. X was clinically X. There was X. X-rays of the X showed X. There were X of the X. MRI of the X showed X. There was X. A X was noted of the X. There was a X. There was X. Findings extended slightly further X. There was up to X in the X. X change was noted X. There was X. There was a X. The treatment to date included medications X. Per a utilization review decision letter dated X, the request for X was denied by X, MD. Rationale: "Per evidenced-based guidelines, X are recommended for patients with significant X corroborated by imaging reports and X. In this case, the

patient was X. The patient does have X. I did discuss the case with X, PA. We discussed that the guidelines specifically recommend X (as requested in this case) when only X is affected. However, in this case, the patient has X. As such, the current request is not supported as there is at least X. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified." Per a reconsideration adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced, this request is non-certified. Per evidence-based guidelines, X are recommended for patients with significant X corroborated by imaging reports and after exhaustion of X. In this case, the patient was X. X had pain in the X. There was a X. A request for X was made. However, there were limited X in the office visit dated X, pertinent to the specific body part as there were X presented in the medical records. Also, there was X presented in the medical records to validate the patient's current condition. In addition, there was no documentation of X. Moreover, presenting X were insufficient to warrant X. Lastly, there was no recent imaging report to corroborate the presented X. As the requested surgery is not supported, the X requests for X are not medically necessary. X PA returned my phone call on X, who has agreed to re-evaluate patient in clinic with X attending and discuss X since this request was recently denied."

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

The claimant is X. The claimant did attend X. The claimant was using X. As of X, the claimant still reported X. Some X exam with X was noted. The claimant received an X at the X evaluation. The response to the X is unclear as no follow up evaluations were included for review. The claimant was recommended for X. X is only recommended in patients with X. Further, X evaluations were included for review to support proceeding with any further X.

Therefore, it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld.

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