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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 X. The diagnosis was X. X was seen by X, MD on X for X. X complained of X. X rated the X at the time. There were no X noted. X had been X. Examination of the X and X. X had a X. X-rays and MRIs reviewed identified a X. An MRI of the X. Treatment to date included X. Per a X, MD on X, the request for X and X was non-certified. X: "Regarding the request for X recommend X. A minimum of X. In addition, X in somewhat X. Regarding X. Criteria for X. MRI also showed X. X done were X and X. Based on the medicals provided, the necessity for X with X. There

were X and X to X, as well as a X. In this case, X was X and the claimant X. Also, considering the claimant's X and X, guidelines would recommend X for the claimant at this time X. X, the request for X to include X. Per a utilization review by X, MD on X, the request for X to include X. X: “A phone conversation was held with the requesting provider Dr. X with a return call at X. The provider states this claimant has X. The claimant has been X but the X. The provider also states that the X. The provider states this X. That is why X is X. The prior non-certification in X was based on the fact that the requested X. The claimant had only X. Additionally, the X. The X demonstrated also X. Per X; the claimant's X. Prior treatment included X. MRI of the X. The provider is appealing the prior determination at this time. The X described X. This procedure sometimes facilitates X. X or X is not recommended for those X. For other exceptional cases, the X the following criteria to be met which include at X. Based on the submitted records and corresponding guidelines, it appears the prior non-certification was not appropriate after a peer to peer discussion. The X noted X. X is medically necessary at this time contrary to the X. Given this scenario, the requested appeal for X to include X.

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

The claimant had been followed for complaints of X. In review of the MRI studies, there was evidence of a X. There was X. The claimant’s X findings as of X noted X. The claimant had used X; however, there was X. In X. In X who X.

Given the X findings as well as the lack of documentation supporting the claimant had X, it is this reviewer’s opinion that medical necessity is not established and the previous 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)

☐ X, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL