AccuReview
An Independent Review Organization
P. O. Box 21
West, TX 76691
Phone (254) 640-1738
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[Date notice sent to all parties]: 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 provider is board-certified in 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: Plan of Care dictated by X. Claimant has demonstrated improvements with X. Demonstrating improvements in X. Claimant will continue to benefit from X.

X: X Note X dictated by X. X of Onset: claimant reported on X. X reported X felt X. X decided to wait as X thought x. However, X. X continued X. Claimant tried X, however, was X. Current X: claimant reported X had X. Reported X. Assessment: claimant has demonstrated improvements with X. Demonstrating improvements in X. Claimant will continue to benefit from X. Plan: X.

X: X Request dictated by unknown. Request authorization for X.

X: X performed by X, DC. Reason for denial: The X allow for X. The claimant has reportedly received X. The request X. Therefore, medical necessity for the requested additional X were not established.

X: Letter of Reconsideration dictated by X. As the treating provider, the claimant is a X with complaints of X. Claimant presented with X. At this point the claimant should be X. Requesting claimant be seen for X.

X: X performed by X. Reason for denial: The claimant presented to X. X was X. There was X at X. The claimant was diagnosed with X. Per X recommends for X. The claimant has previously completed X. The request cannot be modified without provider consent. Therefore, medical necessity has not been established at this time.

X and X by unknown. Reason for denial: Based on the facts we have about your claim, we do not agree that the X.

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

Denial of X. Also given reported continued X. Also given the X. Therefore, medical necessity cannot be concluded at this time. After reviewing the medical records and documentation provided, the request for X.

X

Recommended as indicated below. As with any treatment, if there is no improvement after X, the protocol may be modified or re-evaluated. See also

specific modalities linked below.

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)