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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: The following reviewer is certified by the American Board of X and has over X years of experience.

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.

X

PATIENT CLINICAL HISTORY [SUMMARY]:
Claimant is a X with a history of an occupational claim from X. The mechanism of injury was not detailed in the information provided for review. Current X were not documented for this claimant. The current diagnoses are documented as X. Prior treatment included X.

X: Letter of Medical Necessity by Dr. X. This patient is being followed for X. X is X. X had X. X has X. X on X with up to X relief. Repeated on X with X improvement. X takes X. X does not work well. Chief complaint is X. Does excellent with X. This medically necessary for X as a direct result from this X work injury working for X. Takes X. X is for X. X helps X, as there is X. For this patient, other X give X. Therefore, we agree to X.

X: UR by X. Rationale-X: a specific dose and quantity was not mentioned, plus provider recommended X. X: the documentation submitted for review X. There was no evidence of X documented. X: documentation submitted does not provide evidence of at least X. X: Documentation X. No evidence of X is documented. X: No evidence X. However, X.

X: Letter of Appeal: X Too much activity worsens X. Describing the worse pain of the previous month was X. Least X. X Score was X, which is extremely X. Has signs a X. X Topical: X uses this on X. X has been taking X. X: Pt was noted to have received up to X improvement with this medication. X: Takes this X. Pt had X on X and examination. These X. On X, neuro exam shows "X continues to be X in the X. There is a moderate amount of X.:"X: Previous issues were the use of X was not indicated, so we are currently giving X a trial of X. On X next visit we will document X improvement with this medication.

X: UR by X: Rationale- Peer to peer contact was unsuccessful. X: the efficacy for pain reduction "was not significant." Therefore, the rick ratio benefit needs to be objectively established. X: recommended as an option for moderate to severe pain. Noting date of injury, X demonstrating efficacy with this medication protocol, continued use is not supported. X: not recommended for X. X: there is

no specific objective evidence of a X has not been objectified. X: there is X data demonstrating the utility of this medication, there is no indication for a X, this is not clinically indicated. X: this is supported for short term use only. Given this is a X-decade old injury, there is no clear occasion this particular protocol should be pursued.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION: The previous adverse decision is Overturned. This is a X. This X and not associated with complications. The rational use of X. The literature dictates reasonable monitoring for X. Therefore, the request for Coverage for X 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
☐ 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)