Vanguard MedReview, Inc.
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IRO REVIEWER REPORT

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 case was reviewed by a Board-Certified Doctor of X with experience in X with 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.

PATIENT CLINICAL HISTORY [SUMMARY]:
X: Summary letter by X, DC. Previous X in X. X pain level X. Post X pain level X. X of X on X, post X pain level X. X along with X usage between X to present. Currently, pain is X.

X: UR performed by X, DO. **Rationale for Denial:** I am recommending non-certifying the request for X for the following reasons: with regard to X, according to a X office note on X, there was documentation of the injured worker having X pain with diagnoses of a X in X reportedly decreased pain level from X to X as well as mention of having X. Physical exam revealed X from X, X test X, X and X tests reflex X. The treatment plan included a X. However, there was no documentation of the injured worker having a X condition occurring to support the need for a x and no documentation detailing the specific duration of pain relief and overall functionality that was achieved with the x. Therefore, this request is not in accordance with the guideline criteria and is recommended non-certified.

X: UR performed by X, MD. **Rationale for Denial:** I recommend non-certifying the requested X for the following reasons: The submitted records indicate short lived X improvement form a X provided on X. The submitted records did not document measures of X or a X which has been unchanged at X to support the medical necessity of repeating the procedure. There is X demonstrated on MRI at the X level to support the medical necessity of the requested procedure. Therefore, this request is non-certified.

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

Based on the records submitted and peer-reviewed guidelines, the request is non-certified. The submitted records indicate short lived X improvement X provided on X. The submitted records did not document measures of X or a X which has been unchanged at X since X to support the medical necessity of repeating the procedure. There is X demonstrated on MRI at the X to support the medical necessity of the requested procedure. Therefore, this request is not medically necessary and is non-certified.

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)