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An Independent Review Organization
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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 with a date of injury X. X. The diagnosis was X. On X, X was evaluated by X, MD for the X. The pain X. X was able to X. The pain was rated as X and it was X. Examination of X showed X. An MRI of the X dated X revealed at X. At X, there was X. The X appeared to be X. No X was noted. Treatment to date consisted of medications (X). Per a utilization review adverse determination letter dated X, MD non-certified the request for X. It was determined that the X imaging revealed X. Although Official Disability Guidelines (ODG) recommended X to evaluate a X. The imaging findings indicated that X was not a candidate for X. Thus, as noted, the X was not shown to be medically necessary. As it was not possible to certify all request in full, it was not possible to certify the request. Per a utilization review

reconsideration letter dated X, the request was denied. Per Official Disability Guidelines (ODG), indications for X to determine the level of X. In the case, there was no record of significant X. Only X was noted on imaging at X, with X. In the absence of such clinical questions that could be assessed with X, it was unclear how a X would influence X. Thus, the requested X was not shown to be medically necessary.

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

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review adverse determination letter dated X, MD non-certified the request for X. It was determined that the X. Although Official Disability Guidelines (ODG) recommended X to evaluate a X. The imaging findings indicated that X was not a candidate for X. Thus, as noted, the X was not shown to be medically necessary. As it was not possible to certify all request in full, it was not possible to certify the request. Per a utilization review reconsideration letter dated X, the request was denied. Per Official Disability Guidelines (ODG), indications for X. In the case, there was no record of X. Only X was noted on imaging at X, with X. In the absence of such clinical questions that could be assessed with X, it was unclear how a X would influence X. Thus, the requested X was not shown to be medically necessary. There is insufficient information to support a change in determination, and the previous non-certification is upheld. There is no documentation of a X in a X on the patient's most recent physical examination performed on X. There is no significant X on the submitted X.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the decision is 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