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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 is a X who was injured on X, X. The injury occurred when X. The diagnoses included X. On X, X presented to X, MD with X. Symptoms were X. On examination, X was noted. Examination of the X, as X was in a X. At the X. The X.

There was X. There was X. There was a X. X were X. The assessment included X. Dr. X opined that there was X. X also noted there was X. Dr. X recommended X. X presented to X, DO on X for a follow-up. X had diagnosed with X. X continued to complain of pain in the X. Examination showed that X test induced X. X was X at the X. X were X. Assessment was X. The ongoing X were continued. A CT scan of the X dated X showed X. There was X. An x-ray of the X dated X showed X. There were X. There was X. Treatment to date included X. Per a Peer Review dated X by X, MD, and a utilization review dated X, the request for "X", was deemed not medically necessary. The rationale for the denial was as follows: "This request is not supported. After speaking with Dr. X, X stated the plan is to do X. They are then going to X." The patient has X, per the provider's interpretation of the x-ray. The imaging was discussed in detail. After this discussion, it appears the documentation does not support the request, as it is contradictory in places when describing the x-rays. In addition, it is unclear there is enough support for such a X, therefore, the request is not supported." Per another Peer Review dated X by X, MD, and a utilization review dated X, the reconsideration request for "X", was deemed not medically necessary. The rationale noted that the requesting provider stated that there was X. This was not noted on the official CT scan results dated X. This provider also stated that there was X. Considering the absence of any X noted in the official imaging studies for X, it was opined that there was no justification to pursue a X.

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

The claimant has an X. In review of the X CT study, it is clearly noted that there was X. Dr. X feels that there is a X. There is also X. There is also X. There is X. X will need to go well across the X. X is a X. Anything less will likely result in continued X. Therefore, the levels proposed are reasonable. X can proceed as requested, However, X evaluation would be useful in this case to ensure that the claimant has X. X is also indicated to ensure X is under X. Then the prior denials are overturned.

Given the documentation available, the requested service(s) 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

☐ 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