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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 reviewing physician is certified by The American Board of 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]:
Claimant is a X who sustained a work-related X injury on X. Mechanism of injury was not documented on medical records received. Claimant has experienced X. Due to the persistent pain over the X out from injury, claimant was recommended for a X examination to evaluate the X.

X: X MRI. X- 1.X. 2.X. 3.X.

X: X Note. Active Problem-X. Current Meds: X. X is compliant with X. Pt is X. Pt demonstrates X.

X: X Notes. Pt states X is X. Pt X. Evaluation: 1.X. 2.X. 3.X.

X: X Notes. Total awarded X. Current X. Missed X. Pt reports X. States that X was on X. Pain X.

X: Recheck Report with Dr. X. Pt continues X. On X examination, X. X has X. X. X. X. X. X. X. Recommend X examination to evaluate X. Continue with X.

X: UR by X. Rationale- There is X. MRI showed X. There is an X. On X E. Pt has X. Based on documentation provided, the ODG is not satisfied. Not medically necessary.

X: UR by X. Rationale- Claimant present with X. Claimant has X. Claimant returns with X. With all this, there is X. Furthermore, there were X exam findings noted to X. Therefore, not medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION: The previous adverse decision is Upheld. This patient sustained a X injury in X. X has X. The X MRI of the X identified an X. This study also identified a X. The treating physician recommended X. It is unclear whether the patient's X pain is associated with the X. A n X is recommended prior to X consideration. The

patient may also require a CT scan of the X. Therefore, the request for X is denied and is considered not 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)