CASEREVIEW

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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 physician is Board Certified X with over X years of experience, including X.

**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]:**

The claimant is a X who sustained injuries during a X. Current diagnosis is X.

On X, the claimant presented with symptoms of pain described as X. X described the pain as a X. X also described it as X. The claimant reported that X. On physical examination, there was X. There was X. X revealed pain on X. The pain was noted over the X. The pain was noted with X. The X test was X. Plan: X. X. X. A X due to the patient continuing to be X.

On X, X, MD performed a UR. Rationale for Denial: A request is submitted for a X. A medical document dated X, indicated that subjectively, there were symptoms of pain in the X. It was documented that X was utilized for X. Objectively, there was documentation of pain in the X. There was a X. There was X. The submitted clinical documentation X. There is no documentation provided with X. Consequently, presently, medical necessity for a X as requested is not established and is non-certified.

A request is submitted for a X. There are instances whereby the above-noted reference would support consideration of treatment in the form of a X. However, the documented signs and symptoms appear to be X. The documented symptoms X. Consequently, at the present time, the above-noted reference would not support a medical necessity for a X.

On X, X, DO performed a UR. Rationale for Denial: Regarding the request for X, the Official Disability Guidelines recommend X. The records indicate that the treatment plan included continuation with the X. The letter of appeal dated X noted that the goal of the request was to provide X. However, there was no indication that the patient was X. There was no indication that there was concern regarding X. Therefore, the request for X is non-certified.

Regarding the request for the X, the Official Disability Guidelines recommend X. There should be physical examination evidence confirming pain related to X. The recent physical examination noted X. The patient reported the X. However, there was a lack of physical examination evidence confirming the presence of X. Additionally, the rationale for requesting X to be performed concurrently was not clearly noted. Therefore, the request X is non-certified.

Regarding the request for the X, the Official Disability Guidelines recommend X. The physical examination noted X. However, objective evidence was limited to confirming X to support the request. Additionally, the rationale for requesting X to be performed concurrently was not clearly noted. Therefore, the request for the X 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, I agree with the following recommendations. Regarding the request for X, ODG recommends. The records indicate that the treatment plan included continuation with the X. However, there was no indication that the patient was X. There was no indication that there was concern regarding any X. Therefore, the request for X is not medically necessary and is non-certified.

Regarding the request for the X, ODG recommends X. There should be physical examination evidence confirming pain related to X. The recent physical examination noted X. The patient reported the X. However, there was a lack of physical examination evidence confirming the presence of X. Therefore, the request for X is not medically necessary and non-certified.

Regarding the request for the X, ODG recommend X. The physical examination noted X. However, objective evidence was limited to confirming X to support the request. Additionally, the rationale for requesting X to be performed concurrently was not clearly noted. Therefore, the request for the X is not medically necessary and 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)