



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone:
877-738-4391 Fax: 877-738-4395

IRO REVIEWER REPORT

Date notice sent to all parties: 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:

Board Certified in X

Fellowship Trained in X

Added Qualifications in 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 patient was allegedly injured at work on X. Initial evaluation included CT scans of the X. The X CT scan did not demonstrate any significant abnormalities and the X MRI scan on X demonstrated only a X. The patient was treated with X by Dr. X. There is documentation of varied response to X. Dr. X alleged that the patient obtained X. The patient, however, described X. The patient was evaluated by Dr. X, a X, on X, who found X. Subsequent to that, the patient was evaluated by Dr. X, a X, on X, who contradicted Dr. X opinions and sent the patient for X evaluation, X. Dr. X diagnosed the patient with X. He also diagnosed the patient with X. Dr. X examination, however, did not document any evidence of X.

On X, the patient was evaluated by Dr. X, a X, who documented X. Dr. X did not note any evidence of X. He recommended that the patient be referred for "X." An EEG study on X demonstrated X. X were said to be possibly related to X. An FCE was performed on X and it was noted that the patient's job description was of the X. Minimal X were noted on that evaluation. On X, the patient was evaluated for X by X, and X. In that evaluation, the patient's medical treatment to date was documented, including X report of X Dr. X on or about X. X testing demonstrated X. According to the evaluation, the patient X. The initial physician reviewer, on X, recommended non-certification of the request for X. The reviewer also noted that the patient did X. Finally, the reviewer also noted that the patient had reportedly been X. The reviewer noted that the patient's pre-injury job was at X.

On X, the patient was reevaluated by X who again recommended X. There was no significantly different data submitted with that request, other than X. A second physician reviewer evaluated the request for reconsideration on X, including a direct peer-to-peer conversation with the requesting provider. That reviewer noted the report of Dr. X for his Independent Medical Examination (IME) and found it to be "X," agreeing with those findings. The reviewer noted the "X" and that such a lack with reported physical symptoms was "X." Given the "X" documented in the X evaluation, as well as the lack of significant X.

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

In my review of this voluminous file, it is abundantly clear that there is a significant difference between the IME/RME report of Dr. X and the Designated Doctor Examination report of Dr. X, a X. Given the significant X. There is clearly no significant relevant evidence of X. Similarly, given the patient's job requirement in the X. Moreover, Dr. X recommended that the patient participate in a X. X is not part of a X. In my medical opinion and based on all of the documentation discussed above, the patient is not an X. Therefore, the requested X are not appropriate, medically necessary, or supported by the ODG and the previous adverse determinations should be upheld at this time.

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 JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY 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)