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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 who sustained an injury to X. While X. X was diagnosed with X. X was evaluated on X by X, MD. X noted that X. The pain was rated X. The X. X body mass index was X. On examination, there was X. X had remained the same. X testing was improving. X testing was X. Per the note, an MRI of the X on X showed X. On X, X reported X. X had X. The X. X testing was X. X testing was X. On X, X was evaluated by X, PT. X reported X. On examination, X had X. The X. There was X. X tests were X. A limited X was noted due to the X. X had X. The treatment to date included X. Per a Physician Advisor Determination by X, DC on X, the request for X was not certified. Rationale: “The medical necessity for the requested X was not established. The claimant X. The guidelines allow for X. At the time of this request,

the claimant X. The claimant should X. Moreover, there was no evidence of X as a result of the X. Therefore, the medical necessity for the X was not established." Per a Physician Advisor Determination by X, MD on X, the request for X was not certified. Clinical Rationale: "The history and documentation do not objectively support the request for an X. The claimant X. X status has not been shown and X. There is no evidence that the claimant is X. The medical necessity of this X. Dr. X withdrew this request pending the X."

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: X is not recommended as medically necessary, and the previous denials are upheld. Per a Physician Advisor Determination by X, DC on X, the request for X was not certified. Rationale: "The medical necessity for the X was not established. The claimant X. The guidelines allow X. At the time of this request, the claimant had only X. The claimant X. Moreover, there was X. Therefore, the medical necessity for the X was not established." Per a Physician Advisor Determination by X, MD on X, the request for X was not certified. Clinical Rationale: "The history and documentation do not objectively support the request for X. The claimant has attended what should have been a X. X status has Z. There is no evidence that the claimant is Z. The medical necessity of this X. Dr. X withdrew this request pending the X." There is X non-certification is upheld. It appears that this patient has been authorized for X. Current evidence-based guidelines support up to X. When X, X should be noted. There are X of delayed recovery documented. The patient has completed X.

Given the documentation available, the requested service(s) is considered not medically necessary and therefore 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