

IRO Certificate No: X

## **Notice of Workers' Compensation Independent Review Decision**

**Date of Notice:** X

**TX IRO Case #:** X  
X

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
X.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**  
X

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a X. On X, the patient was seen for a follow up visit related to a work compensation injury. The date of injury was last X. Patient continues to complain of neck and lower back pain with pain scale of X. The patient's previous therapies are X last X.

The patient is tentatively scheduled for X on X, still with pending authorization.

On X, the request for X does not meet the criteria. The medical necessity of the request was not demonstrated. There are no findings on MRI at the level to be X.

On X, a letter of appeal was sent. The writer stated that the patient has met medical and necessary criteria for the approval of X.

On X, the determination for the request of X was upheld. The requested medical treatment does not meet established criteria for medical necessity.

### **1) Is the requested X medically necessary?**

**Answer:** No, the request for X is not medically necessary.

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

The ODG criteria for X.

In this case, the patient is a X who had injury on last X. Patient continues to complain of neck and lower back pain with pain scale of X. The patient's previous therapies are X last X. X was recommended. The ODG criteria for X.

For this matter, based on the review of the medical records, current literature, and ODG guidelines used. The requested procedure is not supported by the guidelines cited, as there is insufficient evidence to establish the safety and efficacy of X. The ODG criteria states that X is not recommended to be performed at X. Therefore, the request for X does not meet medical necessity and previous determination should be upheld.

### **SOURCE OF REVIEW CRITERIA:**

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)

X.

### **REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

## **ATTESTATIONS:**

- X.

The clinical reviewer states the following: X

### **Credentials, Knowledge & Experience**

X.

### **Financial Incentives**

X.

### **Independence**

X.

### **Conflict of Interest**

- X