Independent Review Organization (IRO) Notice of Decision Template WC

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Notice of Independent Review Decision

IRO

Reviewer

Report X

IRO Case number:

X

Description of the services in dispute:

X

Description of the qualifications for each physician or 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:

■ Upheld (Agree)

☐

☐ Overturned

(Disagree)

Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether **medical necessity exists** for **each** of the health care services in dispute.

Information provided to the

IRO for review

X

Patient clinical history

X, date of birth X, is a X diagnosed with cervical sprain/strain and seeking coverage for X. X date of injury is X. The claimant was X. Per the summary of records in the X Peer Review Report, “The claimant reports left shoulder and left neck pain. Pain rated X to X.

The claimant is unable to work. Feels dull, numb, constant, did not exist prior to the injury. The pain does radiate into X scapular area and gives headaches. It is intermittent. Made worse by activities of daily live. Physical exam on most recent report dated X: Musculoskeletal: X is decreased by X in all planes with decreased range of motion on the left side. X has good bilateral hand grips. X has paravertebral spasms on the left side at X. X is able to abduct X left upper extremity to X degrees place X left hand behind X head. X is unable to place X left hand behind X back. Treatment to date includes X. Diagnostic imaging reviewed: MRI of the cervical spine without contrast X: X. X.
Congenitally small canal with mild cervical degenerative change and facet arthropathy, greatest at X: Moderate to severe left foraminal stenosis presumably compressing the left X. Alignment: X. Minimal ventral cord fattening X, and minimal cord contact without flattening at X. MRI left shoulder without contrast X: Mild- moderate X. No X is seen. X fluid."

Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision

A prior request was non-certified noting that, "According to guidelines, X. In this claimant, however, the provided documentation does not support this request, as the claimant's neck pain is largely coming from the X. As such, the requested X is not medically necessary." The denial was upheld on appeal; however, this is an incomplete report, and the rationale is unknown. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. No clinical records were submitted for review. The above summary was gleaned from the prior review reports. There is X. There is X. There are X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

Description and source of the screening criteria or other clinical basis used to make the decision

☐ ACOEM - American College of Occupational and
☐
☐ Environmental Medicine Um Knowledgebase AHRQ -

Agency for Healthcare Research and 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)