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Notice of Independent Review Decision
Amendment x

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:

☐ Overturned Disagree

☐ Partially Overtuned Agree in part/Disagree in part

☒ Upheld Agree

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 [SUMMARY]: X who was injured on X.Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The requested X is not medically necessary. The submitted medical records do not demonstrate the presence of instability lumbar X. In addition, the X does not demonstrate any evidence of spinal X. The guidelines have not been met for the requested procedure. Therefore, the request X is non-certified." Per a reconsideration review adverse determination letter dated "X and X" by X, MD, prior decision for the denial of request for X was upheld. Rationale: "Per Official Disability Guidelines, X. In this case, the claimant has complaints of lumbar X to the left lower X. Physical exam revealed X on the left; X on the left side. X of the lumbar X performed on X revealed a normal exam; X there is X spinal X is noted. There is X. The claimant has continued radicular complaints supported by objective findings on physical examination. However, the claimant's imaging did not reveal any significant X to support a need for X. Therefore, medical necessity has not been established."The provided records did not include any actual clinical evaluations of the claimant, formal imaging reports, or details regarding failure of non-operative measures in order to support the X lumbar X as reasonable or necessary. A pre-operative psychological evaluation was not included for review. Given these issues, it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld. X is not medically necessary and non certified

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

The provided records did not include any actual clinical evaluations of the claimant, formal imaging reports, or details regarding failure of non-

operative measures in order to support the X lumbar X as reasonable or necessary. A pre-operative psychological evaluation was not included for review. Given these issues, it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld. X and non certified
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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**