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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. No office visit note or diagnostic test reports were available in the provided medical records. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “MRI does not show a confirmed X. Per ODG X is recommended as indicated for X. Not recommended for X. This patient has MRI evidence of a X. In the presence of a X. There is a history of X. The patient has had ongoing pain after sustaining a X. Since the X, the patient has X. The MRI does show X. There is X. The patient has X on exam and X. There was X noted on X , but there is X noted on the recent report from X . In the absence of X is not supported. There are also X in the knee in the X. In the presence of X is not generally recommended, as it can accelerate degenerative changes. It should also be noted that the patient is treating for a X in the left lower extremity and was recently placed back on X . It would appear that treatment for X would take precedence over surgery at this point in time. There is no evidence that the patient was cleared to proceed with X on the left lower extremity. Further, the X report is incomplete. The remainder of the report is cut off. I do not have the diagnosis or treatment plan included on the submitted pages. Additional information was requested in accordance with the utilization review standards however no response was received. Given that a portion of the X is not supported, the request cannot be found to be medically appropriate. Requests cannot be modified in the state of Texas without a peer to peer discussion. Therefore, my recommendation is to NON-CERTIFY the request for X.” Per a reconsideration review adverse determination letter dated X by X, MD, the request for X. Dr. X was in agreement and will seek medical clearance from the patient's primary physician.

Therefore, my recommendation is to NON-CERTIFY the request for APPEAL: X." The requested surgical procedure is not medically necessary. According to the medical records, the X report does not demonstrate a definitive X. In addition, the physical examination findings are limited to support the current surgical request. Finally, the patient is actively being treated for a X. There is no indication that the patient is cleared to proceed with the requested X. For multiple reasons, the requested X is not medically necessary. The previous non-certifications 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 requested X is not medically necessary. According to the medical records, the X report does not demonstrate a definitive X. In addition, the physical examination findings are limited to support the current X request. Finally, the patient is actively being treated for a X. There is no indication that the patient is cleared to proceed with the requested X. For multiple reasons, the requested X is not medically necessary. The previous non-certifications are upheld. X is not medically necessary 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)**