C-IRO Inc.
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Notice of Independent Review Decision

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 is a X who was injured on X. Per records, the mechanism of injury was detailed as X. The diagnosis was X. Per records, Progress notes signed by X, MD, on X reported X was complaining of X. X received X. X was planned. A request for X date of service (DOS) X was submitted. Per records, the progress note dated X signed by X, MD, indicated X reported an improvement in X. X had an X on X. On X examination, there was X. There was X. There was X. There was X. Previous treatment included X. The most recent X was dated X and was X was counseled. The most recent X review was on X. A request for X was submitted. Treatment to date included medications, X. Per a utilization review adverse determination letter dated X by X, MD, the request for X date of service (DOS) X was denied. Rationale: "the proposed treatment consisting of X DOS X is not medically necessary for this diagnosis and clinical findings. ODG indicated X is X. Permanently X. Based upon the medical documentation presently available for review, the above-noted reference does X. Guidelines X. Unable to validate the medical necessity of this request at this time given the information provided. Given the clinical findings on examination, X DOS X is not medically necessary. "Per a reconsideration / utilization review adverse determination letter dated X, by X, MD, the request for RECON X date of service (DOS) X was denied. Rationale: "the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Per the ODG by X. The claimant had X. However, X. As such, the request for X DOS: X is not medically necessary. "Thoroughly reviewed provided documentation including peer reviews, provider notes. Agree with peer reviews. While it appears that X. Further, efficacy and necessity of X. 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:

Agree with peer reviews. While it appears that X. Further, efficacy and necessity of 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)**