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Notice of Independent Review Decision
Amendment x

IRO REVIEWER REPORT
Date:X; Amendment 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. X was X. The diagnosis was X. On X, X was evaluated by X, DO for complaints of X. X had a X. X had X. X was consulting a X, Dr. X, who had referred X to Dr. X clinic for a X. On examination, the X. X medications included X. X was diagnosed with X was requested. An X dated X identified X. A X. There was a X. There was X. A X. There was X. Severe X was noted. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “On X, the injured worker reported X. The injured worker's prior treatment included X. A X had requested a X. On physical examination, the X. The injured worker's X. The request is X. There are X There is X. Therefore, the request for X is not medically necessary. Per a reconsideration review dated X by X, MD, the denial for X was upheld. Rationale: “In this case, a previous request was X. This is an appeal. There is X. There are X. Therefore, the Appeal X is non-certified. “On X, Dr. X wrote a letter of medical necessity regarding the denial of X being denied. X stated X had this injury since X. Most recently X was referred to Dr. X from X Dr. X. X had participated in X. X pain was consistently at a level of X. The assessment was X. The ongoing medications included X. X included X with X. Dr. X therefore requested consideration for approval of X. Thoroughly reviewed supplied documentation including X. Though there are some more valid indications for X, there is limited evidence to support other indications. Provider notes that X wants to X. Patient has symptoms around X. Recent X showing some X. Although not normally recommended, X is indicated in this patient. The requested X is medically necessary and certified

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

X is not an often recommended procedure and is only performed in select circumstances to better evaluate X. Though there are some more valid indications for X , there is limited evidence to support other indications. Provider

notes that X wants to X. Recent X showing some X. Although not normally recommended, X is indicated in this patient. The requested X is medically necessary and certified

Overturned

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)**