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Austin, TX 78758 **IRO Certificate #**

Notice of Independent Review Decision

DATE OF REVIEW: X

IRO CASE NO. 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:

Upheld (Agree)

Overturned (Disagree) X

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X
PATIENT CLINICAL HISTORY SUMMARY

This is a X patient who was injured at work on X when X was in a X. There is a diagnosis of traumatic brain injury and bilateral ankle pain with ongoing neurological functional impairments. At the time of the X, there was loss of consciousness and X was transported to the hospital where X underwent a X. X was hospitalized for X months. X was discharged home with family and received outpatient services at that time. X years ago, X moved to X and lived with X for a X months but the arrangement did not go as planned and X was placed in an X. Per assessment on X, X ambulated with a X. At the time of the assessment, X was broken and X was awaiting new X. X was showing improvement in function including being able to ambulate up to X. X was screened for X. X was noted to have X. There are notes in the chart from X that X was waiting for X. There is recommendation from the members of X interdisciplinary team that there is medical necessity to X. There is documentation that payment was processed for a X. Recommendation was made for X. Request for X was submitted. Initial request for X was denied due to X.

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

Opinion: I disagree with the benefit company's decision to deny the requested service.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (continuation)

Rationale:

This review pertains to the need for X. There is sufficient documentation that regardless of the status of the X, the interdisciplinary team is recommending X. There is documented improvement in X.

The requested service, **X, is medically necessary**.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)

Disclaimer:

The opinions rendered in this case are the opinions of this evaluator. This evaluation has been conducted on the basis of the medical documentation as provided with the assumption that the material is true, complete, and correct. If more information becomes available at a later date, then additional service, reports, or reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. The opinion is based on a clinical assessment from the documentation provided.