

## INSTRUCTIONS FOR THE COMPLETION OF THE IRO NOTICE OF DECISION TEMPLATE - HC

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The HC Template should be used specifically for non-workers' compensation **health care (HC)** IRO reviews.

*The following instructions describe what type of information the IRO is being requested to provide in the bracketed language areas of the IRO Notice of Decision and IRO Reviewer Report templates. Language appearing outside of brackets is standard wording and should not change or vary.*

### **[INDEPENDENT REVIEW ORGANIZATION LETTERHEAD]**

This section indicates that the notice of the decision should be submitted on the IRO's letterhead.

### **[NAME AND ADDRESS or NAME AND MEANS OF TRANSMISSION (as applicable) OF ALL INVOLVED PARTIES]**

In this section the IRO should identify each involved party to which the IRO is required to provide the notice of the decision and reviewers report.

#### **For example:**

- Texas Department of Insurance
- Patient or the Person Acting on Behalf of Patient, including an attorney if applicable
- Adverse Determination Provider(f/k/a Requesting Provider or Provider of Record)
- Utilization Review Agent (URA)
- Payor (if different from the URA)

In addition to providing the name of the involved party to which the IRO sent a copy of the notice of decision it should be indicated how the notice of the decision was transmitted to each party. **For example:**

Texas Department of Insurance- HWCN Division MC 103-5A  
VIA E-MAIL [IRODecisions@tdi.state.tx.us](mailto:IRODecisions@tdi.state.tx.us)

[ABC URA]  
VIA FAX [123-456-7890]

[XYZ Carrier]  
VIA FAX [123-456-7891]

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[Patient]  
111 My Street  
My Town, Texas 78XXX]

[Person Acting on Behalf of Patient or Attorney as applicable]  
[111 Any Street  
Any Town, Texas 78XXX]

[Adverse Determination Provider]  
272 Health Way  
Metro City, Texas 78XXX]

**[Date of the Notice of the IRO Decision]**

Provide the date of the decision.

**[TDI Assigned Number]**

Insert the TDI IRO assignment number.

**[Patient]**

In the sections where this bracketed term appears, provide the name of patient.

**[NAME OF IRO]**

Provide the name of the IRO where ever this field appears throughout the notice.

**[IRO Cert #]**

Provide the TDI certification number of the IRO.

**[SPECIALTY OF REVIEWING PHYSICIAN or HEALTH CARE PROVIDER]**

Provide the specialty/specialties of the reviewing physician. If the review was performed by a non-physician provide the type of health care provider that performed the review. The description in this section should not disclose the identity of the reviewer.

**[DATE]**

Provide the date all notices of decision were transmitted or mailed (as applicable) to each of the involved parties.

**[NAME OF IRO REPRESENTATIVE]**

Provide the name of the individual that represents the IRO under whose signature the IRO will provide the notice of decision.

**[TITLE]**

Provide the title of the individual described in the previous section.

**INSTRUCTIONS FOR IRO REVIEWER  
REPORT TEMPLATE - HC**

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**DATE OF REVIEW:** *[Date of Review Report]*

**IRO CASE #:** *[TDI Assigned Number]*

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

*[Provide a description of all disputed services complete with beginning and ending dates of service.]*

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

*[Provide the type of physician or health care provider that performed the IRO review. Include any applicable specialty and/or qualifications of the reviewer(s). Qualifications could include specialty designations or other special training or expertise. The description provided in this section should not disclose the identity of the reviewer.]*

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	(Agree)
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

*[Check only one of the boxes above.]*

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

*[For each of the health care services in dispute list the health care service, date of service, and the outcome of the review of that service. The following table represents the manner in which the URA/carrier is required to submit information on the health care services that are being disputed. The last column Upheld/Overtured is the information to be provided by the IRO as determined by the IRO reviewer(s).]*

**INSTRUCTIONS FOR IRO REVIEWER REPORT TEMPLATE - HC**

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<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Upheld Overturn</i>
401	92000	NA	Prosp			Upheld
712	98224	“	Prosp			Overturn
124	97665	“	Prosp			Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

*[Provide a description of the information reviewed by the IRO during the review. This should include a list of all medical records and other documents reviewed by the IRO, including the dates of those documents. For medical records or documents that include multiple dates, a date range may be used. Example: XYZ Hospital Medical Records 01/01/06 through 5/31/06]*

**PATIENT CLINICAL HISTORY [SUMMARY]:**

*[Have the reviewer provide a brief but sufficient summary of the patient’s clinical history. The reviewer should refrain from using the patient’s name and instead use terminology such as “patient”.]*

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

*[For all reviews: In this section the reviewer provides a description of the basis of the review to include explanations, analysis, clinical basis and conclusions. The reviewer should refrain from using the patient’s name and instead use terminology such as “patient”.]*

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

*[Check any of the following that were used in the course of this review.]*

ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY 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)