Instructions for the Completion of the
IRO Notice of Decision Template - WC

The WC Template should be used specifically for workers' compensation (WC) **non-network** health care 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]

Bracketed language in 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- HWCN Division
- Injured Employee or the Person Acting on Behalf of Injured Employee, including an attorney if applicable
- Adverse Determination Provider (f/ka Requesting Provider or Treating Provider
- Utilization Review Agent (URA) (if applicable)
- Carrier/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

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

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

[Injured Employee]
111 My Street
My Town, Texas 78XXX]

[Person Acting on Behalf of Injured Employee 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.

[Injured Employee]

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

Type of Review:

Check the box that represents the type of adverse determination review.

[Prevailing Party: Requestor or Carrier]

(Applicable to Retrospective Reviews Only)
The IRO determines the prevailing party based on total dollar amount of each upheld and overturned health care service in dispute.

[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 - WC

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)
Overturned	(Disagree)
Partially Overturned	(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/Overturn is the information to be provided by the IRO as determined by the IRO reviewer(s).]

Primary Diagnosis Code	*Service Being Denied*	*Billing Modifier*	*Type of Review*	*Units*	*Date(s) of Service*	*Amount Billed*	*Date of Injury*	*DWC Claim #*	*Upheld Overturn*
401	*92000*	*NA*	*Retro*	*5*	*7/12/06*	*50.00*	*01/01/06*	*DWC01*	*Upheld*
712	*98224*	*“*	*Retro*	*1*	*7/13/06*	*70.00*	*01/01/06*	*“*	*Overturn*
124	*97665*	*“*	*Retro*	*1*	*7/13/06*	*20.00*	*01/01/06*	*“*	*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]

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

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

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

[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 Injured Employee’s name and instead use terminology such as “injured employee”.]

If applicable this section should include the following:

Specific basis for divergence from the Division of Workers’ Compensation (DWC) policies or guidelines adopted under Labor Code §143.011.]

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)