IRO NOTICE OF DECISION TEMPLATE – WC

[INDEPENDENT REVIEW ORGANIZATION LETTERHEAD]

Notice of Independent Review Decision

SENT TO: Texas Department of Insurance
Health & Workers' Compensation Network Certification and QA Division (HWCN) MC 103-5A
Via E-mail IRODecisions@tdi.state.tx.us

[FOR EACH INVOLVED PARTY PROVIDE:

NAME OF PARTY AND US MAIL ADDRESS
or (as applicable)
NAME OF PARTY AND OTHER MEANS of TRANSMISSION]

[Date of the Notice of the Decision]

RE: IRO Case #: **[TDI Assigned Number]**
Name: **[of Injured Employee]**
Coverage Type: Workers' Compensation Health Care (Non-network)
Type of Review:
☐ Preauthorization or Concurrent Review
☐ Retrospective Review
[Prevailing Party:
☐ Requestor
☐ Carrier]

[NAME OF IRO] has been certified, certification number **[IRO Cert #],** by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to the IRO for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

The IRO has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, the IRO reviewed the medical records and documentation provided to the IRO by involved parties.

This case was reviewed by a **[SPECIALTY OF REVIEWING PHYSICIAN or HEALTH CARE PROVIDER]**. The reviewer has signed a certification statement

stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of **[NAME OF IRO]** I certify that:

1. there is no known conflict between the reviewer, the IRO and/or any officer/ employee of the IRO with any person or entity that is a party to the dispute, and

2. a copy of this IRO decision was sent to all of the parties via U.S. Postal Service or otherwise transmitted in the manner indicated above on **[DATE]**.

Right to Appeal
You have the right to appeal the decision by seeking judicial review. The decision of the IRO is binding during the appeal process.

For disputes *other than* those related to prospective or concurrent review of spinal surgery the appeal must be filed:

1) directly with a district court in Travis County (see Labor Code §413.031(m), and

2) within thirty (30) days after the date on which the decision is received by the appealing party.

For disputes related to *prospective or concurrent review of spinal surgery*, you may appeal the IRO decision by requesting a Contested Case Hearing (CCH). A request for a CCH must be in writing and received by the Division of the Workers' Compensation, Division Chief Clerk, within ten (10) days of your receipt of this decision.

Sincerely,

[NAME OF IRO REPRESENTATIVE]
[TITLE]

IRO REVIEWER REPORT TEMPLATE -WC

DATE OF REVIEW:

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

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

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)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

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

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**
- ☐ **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)**