Specialty Independent Review Organization

**Date notice sent to all parties:** 10/31/2018

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
The item in dispute is the prospective medical necessity of XX.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
The reviewer is a Medical Doctor who is board certified in Anesthesiology.

**PATIENT CLINICAL HISTORY [SUMMARY]:**
The patient is a XXXX. Per office note dated XXXX had subjective decreased sensation in XXXX XX but XX suggested XX or XX; the XX and XX were normal. XX testing on XXXX reported normal findings. Per office note dated XXXX patient complains of XX pain. XXXX is XX XX XX on XXXX with XX percent improvement.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**
Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Based on the objective assessment findings on physical exam during the XX block XXXX an objective comparison of findings cannot be fully obtained. A comprehensive evaluation of the patient's condition should be considered to establish the need for the request as well as evidence of a decrease in medication use to validate the noted improvement in overall pain by XX percent. The request remained unsupported as clinical documentation still was insufficient to warrant the need for the request. Therefore, this request is not medically necessary.

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition
Chapter: XX- XX
XX

**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)**