



Specialty Independent Review Organization

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records were received and reviewed from the following parties: X

These records consist of the following (duplicate records are only listed from one source): Records reviewed from X:

X:

Prior Authorization Requests-X,
X

Follow-up Evaluations-X

Procedure Notes-X

X Prior Authorization Requests-X

Appeal Request-X

Orders-X

Physician Evaluation-X

Behavioral Health Status-X

TPI Prior Auth Request-X

Electrodiagnostic Study-X

X:

Physician Advisor Reports-X

LHL009-X

X:

Lab Reports-X

X:

Pre-Authorization Request-X

Progress Note-X

Daily Notes-X

Discharge Summary-X

X:

Re-Authorization Request-X

X:

Procedure Note-X
X MD:
Progress Note-X
X Radiology X:
MRI Report-X

Records reviewed from X:
Center for X:
Follow-Up Evaluations-X
X Prior Authorization Request-X
Electrodiagnostic Study-X

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a X with a history of a claim from X. The mechanism of injury is detailed as a X. The current diagnoses as documented as X. Progress reports documented pain across the X described as X. The pain was rated a X. Prior X treatments included X (X), X with a response. The patient also participated in X that was noted to have X. An MRI dated X of the X was noted to have revealed X noted, prior X. The past medical history included X. The past surgical history included X, X. On physical examination of the X, there was X. Positive X, as well as X, were noted. There was decreased X due to pain. A X sign was positive in the X. X were X and X. The sensation was decreased in the X and in the X to light touch.

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

Per evidence-based guidelines, and the records submitted, this request is non-certified. The ODG recommends

diagnostic X the clinical presentation is consistent with X pain that includes X in the X areas with X pain with the absence of X findings in a X distribution and if there is documentation of X treatment including X, X, and X for at least X with no more than X levels to be X session. The documentation provided for this review describes X pain rated at X with X X due to pain on physical examination. However, the patient reports X symptoms into the X and X, and there is decreased X X as well as to the X on physical exam, and therefore, this therapy is contraindicated per the guidelines. As such, the request for diagnostic X is not medically necessary.

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**
- AHRQ- 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**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**