



14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

DATE OF REVIEW: 6/18/2019

IRO CASE # X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

X.

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

M.D. Board Certified in Orthopedic Surgery and Sports Medicine.

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)



14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	X
X Utilization Review Determinations	X
xMedical Review Co Initial Review	X
X Clinic Pre-Authorization Request Office Visit Notes	X

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X-year-old X with date of injury X. No details of the injury are currently available, but X carries the diagnosis of X of X X. Per the available clinic note from X, X continues to have X pain and decreased X. On exam, X had a small X, decreased, X, and X. X X-ray showed X. It is documented that X has had a good response to prior X with the last being placed in X. It is also noted that X had not had good response to X



14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

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

Per ODG references, the requested X for the patient is medically necessary. The patient has X of the X with documentation of limited response to most X treatments and prior good response to X for approximately X year. This meets the criteria for performing another X for X X and thus the current request should be certified.

**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 KNOWLEDGE BASE
- 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



14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

- 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