INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Records were received and reviewed from the following parties: X, X, MD, and X

These records consist of the following (duplicate records are only listed from one source): Records reviewed from X:
X WC Services:
Denial Letters-X
Approval Letter-X

Records reviewed from X, MD:
X, MD/X XX:
History and Physical Reports-X
Letter of Medical Necessity-X
X:
Patient Report-X

Records reviewed from X:
X XX:
Pre-Authorization Requests-X
X Imaging:
MRI Report-X

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

PATIENT CLINICAL HISTORY [SUMMARY]:
On X, the patient presented with complaints of X pain. The pain was described to be X. The patient also noted X. The

review of systems reveals X pain. On physical examination, the X showed moderate discomfort with X. The patient MRI of the X dated X documented moderate X, generalized X. The patient's prior treatment included X.

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. Per ODG, X are recommended as a possible option for short-term treatment of X pain with using conjunction with active rehab efforts. Not recommended for X or for nonspecific X pain. The guidelines list the criteria for use of X. In this case, the examination performed is very minimal and does not give clear indications of X. As such, medical necessity has not been established. Therefore, the requested appeal for X is not medically necessary, and this request is non-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 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)**