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INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated X.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated X.
3. Notice of Assignment of Independent Review Organization dated X.
4. Health Plan denial letters dated X.
5. Injury Center of X Pre-Authorization Request form dated X.
6. Medical records from X Consultants, LLP date range X.
7. Duplicate records.

PATIENT CLINICAL HISTORY [SUMMARY]:

This X was injured X while X. X has pain radiating down X X had Physical Therapy. On Physical exam, X has diminished X and X in X and X. X current medications include X. An MRI performed on X showed multi-level X. X has not had a X or X consultation. The request is for X and X.

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

The ODG criteria suggest that X do not change the outcome for the majority of patients. This patient has documented X and X, decreased X on MRI, which are the X. An X is unlikely to change these X.

X: An updated review. *Surg Neurology Int.* 2018 Apr; 9:86) reviewed the risks and complications of X and found no long-term benefit to these injections.

The requested procedures are not medically reasonable or necessary.

Therefore**,** I have determined the requested is not medically necessary for treatment of the patient's medical condition.

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)**