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## INFORMATION PROVIDED TO 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. XX plan denial letter(s) dated X.
5. X Chiropractic fax dated X.
    a. X Pain Management concurrent review request for X management dated X.
    b. X Pain Management history of injury report, critical vocational demands, goals, and conclusion.
    c. X Pain Management summary of diagnostics and specialist consultations dated X.
    d. X Pain Management treating doctor's, FCE doctor's, behavioral XX specialist's, pain management/XX medicine specialist's, ODG's opinion(s).
6. X Chiropractic functional capacity evaluations dated X.
7. X reassessment report dated X.
8. X, D.O. reports dated X.
9. Duplicate records.

## PATIENT CLINICAL HISTORY [SUMMARY]:

This X is X that occurred while X. is X months status post-surgery, a X. completed X of a X pain management program pre-operatively. XX had X sessions of post-operative X and X hours of a post-operative X pain management program. remains totally X.

XX request under review is for X pain management.

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

XX ODG (1) states:" XX

XX is no evidence in XX peer reviewed literature that supports repeating pain management programs.

X (2) have advocated for multi-disciplinary pain management programs but found XX are applicable to only a minority of patients. Given XX minimal clinical improvement of this patient, it is not medically reasonable or necessary for X to do X hours of a X pain management program.

1-ODG Treatment Index 17th Edition (web) 2019. Section of FFD, ODG workhardening / conditioning and Section on Pain.

2-X. Multi-modal Treatment of Chronic Pain. Med Clinics N Amer 2016; 100: 55-64.

XX**,** I have determined XX chronic pain management program of X requested is not medically necessary for treatment of XX patient's medical condition.

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**A DESCRIPTION AND T SOURCE OF XX SCREENING CRITERIA OR OTR CLINICAL BASIS USED TO MAKE XX DECISION:**

☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☐ **AHCPR- AGENCY FOR ALTHCARE 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, T 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)**

☒ **OTR EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**