Parker Healthcare Management Organization, Inc.
3719 N. Beltline Rd Irving, TX 75038
972.906.0603 972.906.0615 (fax)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DW
X	X		Prosp	1			X	30
X	X		Prosp	1			X	30

TDI-HWCN-Request for an IRO- 17 pages

Respondent records- a total of 176 pages of records received to include but not limited to:
TDI letter X; IRO Forms; X letter, X; X UR Peer Review X; Clinic X; MRI X; MRI X; X records X; DWC Forms 73; UR Appeal Peer Review X; Radiology report X; X Specialist Consultation Request

Requestor records- a total of 120 pages of records received to include but not limited to:
The Clinic X records X; MRI X; MRI X; Radiology Report; X Medical Centers records X; various DWC73 forms

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a X -year-old X who was injured on X, when XX. The claimant was diagnosed with a X. X-rays on X, were negative for X. An MRI on X, documented moderate X. There was X. The chronicity of the findings was

indeterminate. An evaluation on X, documented complaints of X. There was no significant physical examination change since the previous last office visit. On X, there were complaints of X. There was no change since the previous office visit. An evaluation on X, documented X. There was X. Treatment had included an unspecified amount of physical therapy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:
The request was previously noncertified on X and on X, was due to lack of necessity. The previous noncertification is supported. Additional records included an evaluation on X. Excessive sedation should be avoided. X should be documented on physical examination and corroborated on imaging. There was no objective evidence of X on physical examination. There were no X reporting any X. There was no notation of X of care such as the use of X, X medications. Therefore, the medical necessity for an X has not been established per the ODG guidelines.

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

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

XX 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)