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IRO Certificate #XX

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Preauthorization (2): XX
Letter of Adverse Determination & Peer Review, XX Co., XXXX, DO, XX
Appeal Reply Letter & Peer Review, XX Co., XX , MD, XX
Workers Comp Patient Initial Evaluation & Established Workers Comp, Evaluation only, XX
Physical Exam Office Notes/Follow (6), XX Medical Center, XX , MD, XX
Office Visit Notes, incl History & Physical; XX Clinic, XX , MD, XX
MRI Request(s) with diagram, XX
MRI Reports, XX w/o contrast, Lumbar w/o contrast, XX Radiology, XX
X-ray Reports, XX , 2 views, XX , 2 views, XX , 2 views, XX , 2 views, XX Medical Center, XX
Physical Therapy Preauth; Physical Therapy Daily Notes, XX Medical Center, XX
Workers Compensation Status Reports
ODG: "XX & XX XX" (updated 4/16/19); "XX XX" (updated 4/16/19) (Facet Joint Injections)

PATIENT CLINICAL HISTORY SUMMARY

This is a XX year old XX who sustained a XX work related injury in XX. XX has persistent XX XX pain. An MRI on XX was reported to show XX XX , XX XX with no significantXX . A XX MRI on XX reportedly revealed mild to moderate XX and mild to moderate XX . A physical exam has revealed a XX decrease of motion with facet tenderness, no focal neurological signs. Physical exam revealed XX pain with XX extension, XX , and XX .

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

Opinion: I disagree with the benefit company's decision to deny the requested service.

Rationale: The first reviewer denied the requested procedures based on ODG prohibiting therapeutic XX . Dr. XX in his XX office visit report stated that the procedures

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (continuation)

were diagnostic and if successful, the XX would be performed in both the XX I and XX areas. The criteria were met for ODG in response to the first denial.

The second denial was based on lack of evidence of persistent pain. At the XX Medical Center, the clinical note of XX states that the XX XX symptoms had remained the same with a pain scale of 3. XX pain had increased to a pain level of 6. Dr. XX ' office visit report of XX stated that XX and XX pain persisted with levels of 4 to 6 on a scale of 0 to 10. The concern of the second reviewer has been resolved. ODG criteria as outlined by the previous reviewers have been met. The requested services described in **"Description of the Service or Services In Dispute"** are medically necessary for this patient.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)