



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
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**DATE OF REVIEW:** X

**IRO CASE #** X

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

X

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

M.D. Board Certified in X.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a X. Per the most recent available clinic note, X. X still has X. X exam is X. X had an x-ray of X. According to the notes X has been treated with X. The notes state that X was



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improving with X. The request at this point is for a X.

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

Per ODG references, the requested "X" is not medically necessary. With the patient being a X. For this reason, the current request should be not 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 KNOWLEDGE BASE
- 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



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- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
  - TMF SCREENING CRITERIA MANUAL
  - PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
  - OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES.