Specialty Independent Review Organization

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:
The reviewer is a Medical Doctor who is board certified in X

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
X

The reviewer disagrees with the previous adverse determination regarding the prospective medical X

PATIENT CLINICAL HISTORY [SUMMARY]:
This patient is a X. The mechanism of injury was X. Past medical history was X.

X was diagnosed with a X. X underwent X. A review of the X.

The X. X had continued X. X was X. X range of X. X had completed X. It was noted that the X. X was X.

The X. There was a X. X was X. There was X. There was X. There was X.

The X. X documented X. X was documented as X. MRI was reviewed and X. X was noted X. The diagnosis included X.

The patient’s X. It was noted that X. X had X. X had X. The treatment plan recommended X.

The X determination denied the request for X. The rationale stated that clarification was needed regarding the X as the guidelines stated that injection intervals should be a X. For X. Additionally, there was no documentation of X in the most recent medical report.

The X of continued X. The patient X. X had X. X had X. X had X. The treatment plan recommended X.

The X review determination denied the X as not medically necessary. The rationale stated X to support the medical necessity of this request. Additionally, the date of the last X was not documented.

The X. X reported X had X. X had X. X exam documented X. X exam was X. X was continuing with X. X under X. It was noted that X. The treatment plan recommended X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The applicable Official Disability Guidelines recommend X for the short-term use only. Criteria for X

The applicable Official Disability Guidelines recommend X. Guidelines state that manipulation under X. Indications for X.

This patient presents with X. X preclude X. Clinical exam findings have documented X. X is X. X has X. Under consideration is a request for X. The X of findings evidence significant X. Failure of X. The X. There is now a X. Therefore, this request for X is medically necessary.

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**
- ☐ **AHRQ- 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**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**