Specialty Independent Review Organization

Notice of Independent Review Decision

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:

X

PATIENT CLINICAL HISTORY [SUMMARY]:
This patient is a X who sustained X on X. The mechanism of injury was described as X. Past medical history was X for X.

A review of records indicated the patient was being treated for X of the X. Conservative treatment had included X

The X documented X of the X. Findings documented the X. There was X.

The patient X on X.

The X report cited X. X reported X. Conservative treatment had included X. X exam X. X was documented as X. The X showed X. The diagnosis included X. The patient’s history and physical exam and X were consistent with X. X condition X. X was recommended to X.

The X indicated that X was non-certified. The rationale stated that the patient had X of conservative care, and there should not X.

An appeal request was submitted by the X on X with additional medical records.

The X documented that the request for X was non-certified. The rationale stated that guidelines recommend X. The patient had X on X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The Official Disability Guidelines recommend X with diagnosis of X. Criteria include: X.

The Official Disability Guidelines state that X is recommended as an option for X, following appropriate coding and billing procedures.

This patient presents with X. Clinical exam findings are consistent with X evidence of X. X has X. Under consideration is a request for X. Guideline criteria have not been fully met to support X at this time. There is evidence of X. X has X, and additional conservative treatment is optional as X. However, guidelines do not recommend X when X. Records indicate that X was performed on X. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception to guidelines. Therefore, this request for X is not 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)**