Parker Healthcare Management Organization, Inc.
3719 N. Beltline Rd Irving, TX 75038
972.906.0603 972.906.0615 (fax)
IRO Cert#5301

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes 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 claimant is a X who was injured on X. The claimant was X. The claimant was diagnosed with X. The claimant X. Medications included X. The claimant reported X. Pain was X. On X examination, the X. The X. There was X noted. X

was recommended for the diagnosis of X. Prior treatment had included X. A X evaluation performed on X, suggested the claimant was a candidate for X.

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.

The request was previously non-authorized on X, due to the lack of supporting documentation regarding an in-depth discussion about reasonable expectations for pain relief with the procedure and its potential complications. The prior non-authorization is supported. There should be evidence that the claimant has X. There should be evidence that other X, which has not been documented. There should be evidence that the claimant has X. The records suggest that the claimant reports X. A X is recommended for use in X. There is no documentation that the claimant has been recommended and is X. Again, an in-depth discussion about reasonable expectations for pain relief with the procedure is recommended, especially noting that the claimant has X. An in-depth discussion regarding X

, is recommended as well. There is no documentation to support these in- depth discussions. Therefore, the medical necessity of X has not been established. The request for X is non-authorized.

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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 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

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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)