DATE NOTICE SENT TO ALL PARTIES: 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
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

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties: X

PATIENT CLINICAL HISTORY [SUMMARY]:
Patient is a X who sustained an X when X. The MRI of the X. X examination on X. X level was X. It felt X. The X was described as X. On examination, X. X in X. Per exam on X,

patient complained of X. The X level was X. The X felt like X. The X made X. There were no X. There were no X. Prior treatments included X. Treatment X. The current request is for X.

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

Per X, the patient criteria for X:

(1) X must be well documented, along with X findings on X examination. X must be X. A request for the procedure in a patient with X requires additional documentation of recent X.

(2) X to X.

X for use of X:

Note: The purpose of X is to X. There is no evidence that X alone offer any X.

(1) X should be X. X guidance is not recommended.

(2) *X:* At the time of initial use of an X should be administered. A X is not recommended if there is X. Approval of a X documentation of the response to X. There should be an X. This recommendation only applies to the X.

(3) *Repeat X:* Repeat X are not routinely recommended unless there is evidence of an X. This X is based on an X. Evidence indicates that X should be restricted to patients with X. Therefore, the following criteria should be considered:

 (i) Repeat X.

 (ii) Repeat X is better supported with documentation of X.

 (iii) Based on X.

(4) Best evidence does not support routine use of X. No more X.

(5) No more than X levels should be X.

(6) No more than X level should be X.

(7) The X is recommended X. Research is available on X.

(8) Administering X on the same day as other X.
(9) X and X should not be administered on the same day to avoid X.
(10) X is not generally recommended. When required for X.
(11) X is not a stand-alone procedure. There should be evidence of active X. This can include a X.

Per X is recommended as a short-term treatment for X. In the case, the patient complained of X. Treatment plan included X. However, X were not evident to justify this request. There were no objective findings of recent symptom worsening associated with X. Moreover, guidelines further stated that this treatment should be administered in X with X, which was not specified in the medical records to justify this request. Per evidence-based guidelines, and the records submitted, this request is not medically necessary at this time.

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)