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**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. The reviewer has been practicing for greater than X years.

**REVIEW OUTCOME**

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

X

**PATIENT CLINICAL HISTORY [SUMMARY]:**
This patient is a X who sustained an industrial injury on X. Injury occurred when X and X. Past medical history was X. X was diagnosed with X.

The X MRI impression documented X. There was X. The X. The X. There was likely at least a X.

The X orthopedic report cited complaints of X. X reported that X. Current medications included X. Body mass index was documented as X. X exam X. Active X was documented as X. The injured worker had a X. The treatment plan recommended X.

The X utilization review determination letter indicated that the request for X was non-certified. The X utilization review determination letter indicated that the denial of the request for X was upheld.

The X orthopedic report cited complaints of X. X reported that X was X. X exam documented X. Active X was documented as X. The patient had a X. It was noted that the denial of the request for X was being appealed.

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

The Official Disability Guidelines recommend X. Surgical criteria include X.

This patient presents with complaints of X. X underwent X. Clinical exam findings are consistent with imaging evidence of X. The X states X has a X. Under consideration is a request for X. Guideline criteria have not been met for this X request. There is extremely limited X. Body mass index is documented as X. There is no X. There is X 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)