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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:
X

REVIEW OUTCOME:

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
X with a date of injury of X. X reported X. X was diagnosed with X. X was seen by X, MD /X, FNP from X. On X, X presented for evaluation and treatment of X. X reported X. X experienced pain since X. X had X. X had X. The pain was described as X. X complained of pain in X. The X was at X at X. The symptoms were X.
X also experienced X. On examination, there was X. On X, X presented for a follow-up of the X. The pain was rated at X. Since X prior visit, X had X, but unfortunately experienced X. X was interested in X. On X, X returned to the X. The pain was rated at X. Since X prior visit, X had tried X, but experienced X. X reported X. On examination, X were noted. An X of the X dated X showed a X. There was X. Treatment to date included X. On X, Dr. X provided a prior authorization request for a X. X was asking for a X. A X. The X. There was a X. At the time, X. This system was X. The service was X. X suffered from X. X ongoing X. X had been diagnosed with X. X had tried X. They were seeking a way to improve X. X was the next in X. The procedure being requested was X. X has been studied extensively with X. Dr. X submitted a X requested X. Per a utilization review adverse determination

letter dated X, the request for a X by X, MD. Rationale: “Proceeding with a X is not indicated at this time. The worker presented with X, and the provider observed X. However, the X. Therefore, a X. Based on this discussion, the request for X.” A phone call to the office of X, MD at X was attempted on X at X. The provider was X. X was received X. In an appeal letter dated X, X, MD documented that the denial of this procedure was X. The denial letter indicated X. Dr. X provided clarification of the procedure being requested. X submitted X. Per a reconsideration / utilization review adverse determination letter dated X, the prior X, MD. Rationale: “Regarding X, the Official Disability Guidelines X. While it has been suggested that X. Data on these techniques has X. X has not X. Both X. X Involves X. There is X. After the review of the submitted documentation, the appeal request for a X. The cited guidelines X. While it was X that X continued to experience X. The use of X. There was also X . For these reasons, the recommended X . Therefore, the appeal request for X.” Extensively reviewed prior documentation including X. Patient has X. Because of X. These may have been related to X. At this point X. While the placement of a X . Therefore, the appeal request for X.”

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

Extensively reviewed prior documentation X. Patient has X. Because of X. These may X. At this point X. While the placement of a X. Therefore, the appeal request for X.”

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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL