



17304 Preston Road, Suite 800 | Dallas, Texas 75252
Phone: 214 732 9359 | Fax: 972 980 7836

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

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

X

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a X with a date of injury X. X is diagnosed with X.

X is status X. X typically takes X and X. X last X were on X. According to the clinic note by X, the patient has been having X. It X with X. There is also X. After about X of X. X exam shows X. The request is for an X of the X. X of the X were also X. There is X with X. There is X. Also noted is an X with X. A note by X, PA X, states that X exam shows X. X is X on the X at X. There is X in the X. X concludes that these are X.



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

Per ODG references, the requested "X.
According to the X ODG, repeat X "is
recommended to X. In this case, the patient has
X. Based on the provider's most recent note,
there is a X. Given new X, the 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
KNOWLEDGE BASE
- AHCPR- 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



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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 USED GUIDELINES