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

Notice of Independent Review Decision

DATE OF REVIEW: X Date of Amended Decision:X IRO CASE # X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

"Х.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Х.

REVIEW OUTCOME

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

☑ Upheld (Agree)☑ Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

<u>X</u>

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is an X who was injured on X when X X. Currently the patient is complaining of back pain with radicular component and bilateral hip pain. Current diagnosis is sacroiliitis. The patient has had X. Patient X. On last reported physical exam on X, X.X.

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

Per ODG references, the requested "X" is not medically necessary.

Patient is a chronic pain patient with history of X. Although the patient 's exam was positive for X. Therefore, the request for X is not certifiable.

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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 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
ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

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 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