IMedReviews
14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	X
X XX XX Adverse Determination Appeal Determination Denial	X
X Initial Evaluation Note Occupational Therapy Progress Note	X
X Appeal Letter Office Visit Note	X
X Clinical Notes	X
X, MD Designated Doctor Report	X
XX XX;X, MD Peer Review Report	X

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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X who sustained a work injury on X when X X was XX between a X. X is diagnosed with a X by EMG but determined to be a non-compensable condition to this injury. X has had x-ray and CT scans documenting X X abnormalities. Per the notes the patient has completed X sessions of therapy with documented improvement X by therapy notes. The notes indicate X was approved for X visits but there is only documentation of completing X. At the last office note dated X was noted on exam to have no X, X. The request now is for additional X visits.

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

Per ODG references, the requested "X sessions of X as requested by Dr. X, MD" is not medically necessary. This request has been denied previously twice due to already exceeding the allowed number of X visits for the compensable injury of a X. I would agree with the previous decisions that this request should not be approved with the same rationale that adequate X has been done per ODG guidelines and that the patient has no X to progressing to X program. There is not documentation of new injuries or setbacks that would delay healing and constitute extenuating circumstances to approve the request for prolonged X.

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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
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

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☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

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

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

FOCUSED GUIDELINES