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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X: Office Visit with X, DC
X: Texas Workers' Compensation Work Status Report
X: Office Visit with X, DC
X: UR by X, MD
X: Request for Reconsideration
X: UR by X, DC

PATIENT CLINICAL HISTORY [SUMMARY]:

Claimant is a X that was in a work related XX XX accident on X; in which, X. X suffered X pain, X pain, X, X, X pain and X, X pain.

X : Office Visit with Dr. X. X pain. X. The pain interferes with X XX. XX are painful. X pain is alleviated with X and X. Pain is aggravated with X movement. X reports X had not experienced prior symptoms similar to X current complaints and was symptom free at the time of the aforementioned accident/onset of X. On Exam: X with X. X test, positive X and X test. X -X. LROM in all planes. X limited around X. Tenderness with palpation. X with palpation at the X region. X test does reproduce some pain in X. X Test is somewhat X. X. X of X. X limited multiple planes. X pain down X Test is positive. Tenderness in the X. Recommend PT to help decrease the pain.

X: Office Visit with Dr. X. Symptoms of X pain, X pain, X pain and X, X pain. Pain is X. Tenderness to palpation over X region, X region. X in the X and X region. Intact sensation in the X as well as the X. X over X strength X as well

as the X. X has completed X sessions of X with improvement in pain levels and ROM. Recommend continuation of X for an additional X sessions in effort to achieve functional goals that are physical requirements for productive physical functioning and prevention of further physical decline. Continue pain management.

X : UR by Dr. Rationale- Tenderness to palpation over X region, X, X region. X in the X region. There was documentation of Intact sensation in the X as well as the X. Previous treatment is reported to have included X sessions of X services. The above noted reference would support an expectation for an ability to perform a proper non-supervised rehabilitation regimen when an individual has received access to the amount of supervised rehabilitation services previously provided. Consequently, presently. Medical necessity for treatment in the form of X services X is not established.

X: Letter of Medical Necessity by Dr. X. This request was denied stating the request for X sessions of X exceeds the ODG Guidelines. The patient has completed X sessions of X with improvement in X and decrease in pain levels. The patient's current diagnosis is X

X, suspect, a X. X has been prolonged. Therefore, X therapy is warranted.

X: UR by Dr. Rationale- Previous treatment is reported to have included X sessions of X services. We discussed the current subjective/objective findings, ODG recommendations, and need for future care regarding the injuries. There were no extenuating circumstances or significant co-morbid conditions, which would necessitate a continuation of care beyond ODG based upon our decision. Current requested appeal for X is non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION: The previous adverse decision is X. The request exceeds number of visits and time frame for submitted diagnoses, and clinically after completion of X since injury, there is lack of information regarding instruction in and compliance

with a X program, X modification, and any consideration of progression to a more comprehensive functional rehabilitation program. Therefore, the request X is considered not medically necessary.

PER ODG:

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

☐ PRESLEY 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)