17119 Red Oak Rd
Unit # 90333
Houston, TX 77090
281-836-6171

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X Authorization request form
X XX workers compensation uniform medical treatment form
X Progress note by X, XX
X Authorization request form
X Progress note by X, DO
X MRI X report, X
X Request for reconsideration letter X, LLC
X Letter of Appeal
X Initial consultation note by X, DC
Texas Workers compensation work status report
X Daily progress and procedural notes by X, DC
Request to change treating doctor form
X New patient visit notes by X
X Transitional visit notes by X
X Follow up visit notes by X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was reportedly injured in X on X when it was X and X X and X developed pain in X X. There are no records provided from X. X had reported

X, X. X was followed by Dr. X in X and X for X pain and X. There was local X pain and X, but no X on physical examination documented. Dr. X began to work with X in X. X reportedly had X symptoms. The exam showed X reflexes. There was X in the X. The pain drawings showed X pain in the X. Dr. X described X in the X. X had problems on X. X had X signs. X reportedly gave X pain on the X at X degrees and X on the X. There was no report of any symptoms in the X distribution on X.

The MRI of the X dated X showed X with X levels. The radiologist reported X. There were X. The MRI showed displacement of the X. There was also reference to a X MRI for comparison.

X saw Dr. X initially on X and follow up visit on X. On X evaluation by Dr. X, X reported pain in X greater on the X with X symptoms posteriorly X to X. X rated X pain an X. Conservative treatment tried was X care at Dr. X, X, X, X, X and other over-the-X, as well as physician-guided X. On exam, there was pain on X region, pain noted over the X on palpation, X pain X, and no X. X was noted to be X degrees and caused pain, X was noted to be X degrees and caused pain, X was noted to be X degrees and caused pain. Dr. X reported no X or X. Dr. X recommended X, X, X and also mentioned the need for new X.

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

According to Official Disability Guidelines (ODG), the criteria for the use of X require presence of X. X (due to X, but not X) must be well documented, along with objective neurological findings on physical examination. In this case, the current MRI findings showed X compromise. There were subjective complaints of X symptoms and X, but there is no documentation of physical exam showing any X such as X to support the diagnosis of X to warrant X. Therefore, the request for X was not medically necessary and supported by ODG.

In regards to X, according to ODG X are not recommended for X. Current research is minimal in terms of trials of any sort that support the use of X for X. The records submitted revealed physical exam only documented X upon palpation at X, which is not consistent with imaging to support the request for X. Thus, the request for X is not medically necessary and appropriate.