MEDRX

530 N. Crockett #1770 Granbury, Texas 76048
Ph 972-825-7231 Fax 972-274-9022

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

X XX
Dr. X

These records consist of the following (duplicate records are only listed from one source): Records reviewed from:

Dr. X
- Encounter/Visit notes, multiple dates
- Physical Therapy prescription X
- X Rehabilitation Progress Evaluation X
- X Rehabilitation Daily Notes, multiple dates
- X Imaging MR imaging report X

X XX
- Notice of Reconsideration Adverse Determination X
- X Orthopedics Pre-authorization request X

A copy of the ODG was not provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was injured when X jerked the X while working. X had an immediate X pain. X medical history included a previous X, X. X chronic medications included X for an X, X for pain, X for anti-inflammatory action, X for XX loss, and X for XX. X was an X, and X also had a diagnosis of X. The doctor noted decreased range of motion in the X along with X.

An MRI of the X reported X. An MRI of the X reported a X of the X. There was X space.
X went to X and the therapist reported on X that X had X range of motion from X that had improved from the initial evaluation. Dr. X recommended surgery on the bases of failed X. The doctor has recently recommended referral for evaluation of X.

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

The request for X is not medically necessary and is non-certified. This claimant is X years old with XX XX-XX XX in the X as reported on the MRI. X MRI is actually quite good for X XX and X XX XX. X has a X. It is not clear how much X was provided.
ODG recommendations for X require extensive X care including X. This claimant has co-X treated with X, X treated with X, previous X, and X is an X. All of these issues X surgery. X has near normal X pain. The X is stable with no objective X. X has good strength in abduction and X has no atrophy in the X region. This claimant not only does not meet criteria for surgery, X is a XX XX candidate for surgery. Therefore, the requested procedure is not medically necessary and is non-certified.

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**

☐ **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**

ODG Recommendations for XX XX XX XX

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

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

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**