MEDRX

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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

X for X
X, XX, PA

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

X, XX, PA
Radiology Report, X Imaging X
Request from Dr. X for peer to peer consult with reviewing dr
Preauthorization request form
Dr. X Visit Notes, X
X Visit Notes X
Final Radiology Report, X Medical Services X
TDI Form DWC069, Report of Medical Evaluation and clinical evaluation of designated doctor (exam date X)

X
Adverse Determination letter, X
Peer review by Dr. X
Adverse Determination letter, X
Peer review by Dr. X
Request for reconsideration, Dr .X, X

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

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant was injured when X X. X had an onset of X pain that radiated to the X. X had a X MRI that reported a X with X. Repeated physical examinations by Dr. X and others reported X. X had positive X. The designated doctor reported an absent X on the X, but that is not consistent with the other examinations. X had two X that provided two weeks of relief. Dr. XX has recommended a X.

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

The requested X is not medically necessary and is non-certified.
ODG recommendations for X are as follows:
Symptoms/Findings which confirm presence of X. Objective findings on examination need to be present. X test, X and X exams should correlate with symptoms and imaging.
Findings require ONE of the following:

This claimant is X with X extremities. There is no evidence of X causing X symptoms; X had X tightness. The MRI showed a X with no X effects and no X. The claimant had limited relief with X.

There is no X, there is no X. X has X for radiculopathy. X is X intact and has a minimally positive MRI. X does not meet criteria from either the ODG or other peer-reviewed standards of care for the invasive procedure; therefore, the requested X 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**

- [x] **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

- [ ] **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)**