CALIGRA MANAGEMENT, LLC
344 CANYON LAKE
GORDON, TX 76453
817-726-3015 (phone)
888-501-0299 (fax)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

TDI:
- Utilization Review (X)

XX:
- Office Visits (X)
- Diagnostic (X)
- Physical Therapy (X)
- Utilization Review (X)

XX XX, M.D.
- Office visits (X)
- Diagnostics (X)
- Physical Therapy (X)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X who was injured on X, when X. X reported something X. X denied hitting X.

On X, the patient was seen by X at X emergency department (ED). The patient had X. X complained of X pain. On exam, X was noted in the X. X was noted over the X area without X. There was pain with passive X with the X. The patient was diagnosed with X. X and X were prescribed, and X was recommended.

On X, a magnetic resonance imaging (MRI) of the X was performed at x ER and interpreted by X. M.D. The indication of the study was X pain. The study showed no vertebral body XX loss. X was mild at X. Minimal X was nonspecific. There was mild X of the lower XX XX.

On X, x-rays of the X showed X On the same date, x-rays of the X and X were performed, and the study was unremarkable.

On X, X, M.D., saw the patient for X. X continued to have pain in the X. The pain level was X, worse with X and better with X with X. On exam, tenderness was noted along the X, X, X and X. There was a limited range of motion (ROM) due to pain and X. The diagnoses were X, X, X. The patient was recommended X.

On X, the patient was seen at X Clinic for an initial X evaluation. X was recommended X.

On X, the patient was seen by X from X Associates for continued X pain X more than the X side, X and X pain. The patient rated the pain at X. The pain was increased with X, X. X reported pain X did help to decrease the pain but X. X program (X) and X and X were continued.

On X, Dr. X noted the patient continued to have X pain, rated at X. The patient reported currently prescribed medications were not helping to control the pain. The diagnoses were X. X and X were prescribed and X or X was recommended. MRI of the X was ordered.

On X, an MRI of the X was performed at X and interpreted by X, M.D. the study was compared with X, XX, and x-rays of the X dated X. The study showed there were new findings of X involving the X. Otherwise, there were no significant interval changes. At X, there was a slight reduction in normal X. There was small X zone. Superimposed severe X contributed to mild central X, mild X and mild X. The degrees of the X and X appeared stable. There was new X with X, compatible with X. At X, Similar moderate loss of the X, X changes were noted. A X contained a posterior X. X was seen in association with X, mild X resulting in mild X, moderate X and moderate X. Overall findings were stable. There was significant X which encased and X.

From X, through X, X, M.D. saw the patient for continued non-radiating X pain, rated at X. The patient had attended multiple X sessions. X reported minimal-to-no help with medication. The pain was worse with X and was better with nothing. On exam, X were diminished in the X. There was X pain on X in the X. The diagnosis was X, X X followed by X was recommended.

On X, the patient was seen by Dr. X for X pain. The pain level was X at worst and X at best. The patient reported no significant changes since the last visit. The pain radiated into the X. On exam, X was poor. X test was positive on the X. There was a sensory deficit in the left X. The diagnosis was X, X. Dr. X recommended X

On X, Dr. X performed X at the X level.

On X, Dr. X noted overall more than X improvement in X pain after X. The patient was able to X. X reported an improvement in overall by greater than X. X was continued. The patient was advised follow up as needed for re-evaluation and possible X benefit of X or greater relief X.

On X, the patient was seen by Dr. X in a follow-up visit. The patient reported an improvement in pain by more than X after the procedure (X). The patient was able to X. The current pain level was X. The pain level was X at worst and X at best. However, X reported pain returned and would like another X. On exam, X was poor. X were diminished in the X. X test was positive on the X. The plan included a X level

On X, the patient was seen by Dr. X for continued X pain. The pain level was X at best and X at worst. The diagnosis was X, X of the X. The X was not approved by the insurance company.

Per Utilization Review dated X, the request for X with imaging guidance between X, and X, monitored under anesthesia was denied. Rationale: "*Proceeding with the request for the X is not appropriate. Recent exam findings noted ongoing X pain. Additionally, the most recent imaging study in X did not reveal any X at the levels of the requested X. Recent objective findings only noted nonspecific X and a nonspecific positive X. The ODG states that X must be documented by exam findings and corroborated by imaging studies prior to proceeding with X. The X is not warranted as there are no objective findings of X at the level of X corroborated with X on an imaging study to proceed with the injection at this time. Based on the aforementioned, the prospective request for X with imaging guidance is non-certified.*"

Per Reconsideration dated X, by X, M.D., indicated the request for X was denied based on the following rationale: "*Based on the medical records, it does not appear the request for X is warranted. Dr. X has requested X at least four times and each request has been denied due to objective findings not meeting the guideline requirements, including the most recent review, X. There has been no significant change in the claimant's condition. Review of the records indicates X has had complaints of non-X*

pain since the onset of X injury. Only the most recent office visit noted the claimant had complaints of X pain. However, objective findings have never indicated X is present. X MRI performed in X did not reveal any X at the X levels. Recent objective findings noted nonspecific X. There are no objective findings of X at the level of X on the exam that can be corroborated with an X on MRI. The ODG states that X must be documented by exam findings and corroborated by imaging studies prior to proceeding with X I agree with Dr. X that the request is not warranted, as the claimant does not meet the guideline requirements. Therefore, the request for the X is not certified."

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

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES