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INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X– MRI Results-X, MD
X–Physician Notes-X, PA
X– Physician Notes-X, PA
X– Physician Notes-X, PA
X– Rehab without X-X, OTR
X– URA Determination-X, MD
X– URA Re-Determination-X, MD

PATIENT CLINICAL HISTORY [SUMMARY]: Patient is a X year old X who was injured in X. X provider is requesting a X program and the insurance company is denying it.

X– MRI Results-X, MD: MRI X. Hx: X evaluate for post-X, acute X, not intractable. Comparison: CT XX X reported as unremarkable. Findings: X: The X are unremarkable in appearance. No X or X is present. X: The X of the X are normal. X: The X at the base of the X. X normal. X: The X are unremarkable. X: Minimal X changes are suggested. X: The X are unremarkable. X soft tissues: The visualized X are unremarkable. Impression: Unremarkable MRI of the X.

X –Physician Notes-X, PA: CC: X is a X yr old X. This is a f/u visit. This visit is covered under WC. Date of injury: X. HPI: Therapy seems to be helping X with X therapy. Recommended to placing on X. Complains of X; it is of X. The typical duration of an episode is the majority of the day. Aggravating factors include movement and general and movement. Nothing relieves the symptoms.

Associated symptoms include X. X X. Pt states X is not helping X. Assessment: X. Plan: Chronic X; continue current meds. F/u: Return to clinic if symptoms worsen or change. If X has any problems taking the meds or has any other medical reason to be seen. To ER for worsening of symptoms; 4 weeks. No work.

X– Physician Notes-X, PA: CC: X is a X yr old X. This visit is covered under WC. Date of injury: X. HPI: Pt continues w/X therapy and X thinks it has helped X X processing, X. Pt complains of X. Onset was X months ago. The location is primarily behind the X. The pain radiates to the X. X characterizes it as X-like". Associated symptoms include X. Pt states heads are still "constant" and "never goes away". Pt states X goes to X. Assessment: X Plan: It seems from the pt that X is liking the CT and seems to show signs of improvement. I am requesting additional sessions for the pt per the therapist. F/u: Return to clinic if symptoms worsen or change, if has any problems taking the meds or if has any other medical problems requiring attention. Pt advised to return to clinic if symptoms worsen, change or persist, if has any problem w/ med or has any other medical reason to be seen. To ER for worsening of symptoms 4 wks. No work.

X– Physician Notes-X, PA: CC: X is a X yr old X. This is a f/u visit. This visit is covered under WC. Date of injury: X. HPI: Pt claims therapy is going good, X feels as if it's not helping. Claims X is still bothering X. X says the pain is still severe. X starts off w/pain level of 2-3 then slowly escalates throughout the day. Pt has X hasn't gotten any better. X is attending X therapy once a week because X has a number of visits. Wishes to raise dosage on X. Pt continues w/X therapy pt thinks it has helped X X processing, X. Pt complains of X. Onset was X months ago. The location is primarily behind the X. The pain radiates to the X. X characterizes it as X-like". Associated symptoms include X. Pertinent past medical hx includes X. Pt states X are still "constant" and "never goes away". Pt states X goes to X therapy twice a week. Testing indicated that pt seems to have stalled on X recovery and advancement. Pt tells me X is having trouble w/XX XX, and still has a X that get worse different times of a day. XX X skills are taking longer than usual too. Assessment: X Continue current meds. F/u: Return to clinic if symptoms worsen or change, if has any problems taking the meds or if has any other medical problems requiring attention. Pt advised to return to clinic if symptoms worsen, change or persist, if has any problem w/ med or has any other medical reason to

be seen. To ER for worsening of symptoms 4 wks. No work.

XX – Rehab without XX XX-XX XX, OTR: Diagnoses Served: Traumatic XX XX;

XX – URA Determination-XX, MD: XX has been asked to review the treatment listed below for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor made the following decision that the services below are not medically necessary or appropriate. This means we do not approve these services or treatment. Services Requested: XX (40 days) XX; Determination: Non-Certified. Diagnosis/Description: XX. List of Medical Records Reviewed: -XX clinic note XX; -Request for XX treatment notes from XX MRI XX w/o contrast. Clinical Summary: XX. Comorbid diagnoses include XX. Adverse reactions to XX and XX, also took XX med but does not XX XX; recently approved for on XX XX XX in day program, 1 session per week for 8 weeks (XX). XX clinic note requests initial 40 days of XX therapy for PT, OT, XX therapy, XX, XX therapy. Decision: Non-certified. Clinical Rationale: Based upon the available documentation and noted guidelines, it is not recommended for approval for the requested services as reasonable or medically necessary. I do not appreciate significant improved objective measured outcomes from recent approval of post-acute X in day program, 1 session per week for 8 weeks to support more intense treatment. I do not appreciate specific initial evaluation to post-treatment eval that describes summarization of outcomes to treatment in an objective measured description.

X– URA Re-Determination-X, MD: X has been asked to review the treatment request below for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor made the following decision that the services below are not medically necessary or appropriate. This means we do not approve these services or treatments. Services Requested: X); Determination: Not-certified. Diagnosis Codes/Descriptions X duration, sequela. Clinical Summary: This is a X year old claimant injured on X and diagnosed X duration. Claimant was injured in a X. Comorbid diagnoses include X clinic note requests initial X days of X therapy for PT, OT, X therapy, X, X therapy. X causing IW to X after being X, reports X”. Was discharged home for ED after CT XX was unremarkable, but there was loss of X of accident. Deficits have been persistent w/o treatment until X. Has attempted return to work on 2 occasions w/o

success. First attempt was not able to X as X would get XX. Second attempt was in X, but persistent use of X limited X ability to function safely. Therapy goals include X. X would like to eventually take a X and move XX to X where X XX XX a X company. Pain management is a significant X due to persistent X. Other options would be inpatient for intense XX or X injury program. Program requested would occur in XX own home or community. Current treatment program reports XX XX due to XX burden due to pain and fatigue issues. X reported, none w/in past X months. X per month unable to get out of XX due to X pain. Medical records indicate X w/possible XX injury to X, but there has been limited evaluation. Current meds are X pain and XX management and X for XX. Awakens X times per night and sometimes does not XX for X days. Uses X queues. XX XX stays w/X at times but is XX, has a X. XX XX twice per day, once at XX and once at XX. Modified independent w/ADLs. Has XX, difficulty XX for X and X sight, XX XX at all times. Has moderate X deficits, difficulty w/X finding and deficits w/XX of X. Can XX XX XX but has difficulty w/XX X. Expresses XX over XX and continued XX related deficits from X injury. Prior reported treatment: X program setting 23 visits. X: unremarkable MRI of the X. Request: Comprehensive X days). Clinical Rationale: Regarding X days, there is prior denial for this treatment due to lack of objective evidence of benefit derived from X to date. There is no new information provided w/this request to address prior rationale for denial and support a change in determination. Recommendation is to uphold prior non-certification.

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

Denial of X Program is UPHELD/AGREED UPON since there is no objective evidence demonstrating improvement with previous X post-acute X visits, with documentation that "testing indicated that the patient seemed to have stalled on X recovery and advancement," reports of poor attendance, and modified independent functional level with technological aides. Therefore additional comprehensive X is not medically necessary.

PER ODG:

ODG Criteria

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**

☐ **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)**