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IRO Certificate X

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Letter of Adverse Determination & Peer Review,. Corp/X, DO, X
Reconsideration Reply & Peer Review ,X. Corp/X, MD, X
Encounter Notes (5), X Orthopedic & Sports Medicine, X, MD:
Dates: X (X, MD), X
Occupational Therapy Report, X, X(4 visits:X
Pain Management Procedure Report (2), X, MD, X
Clinical/Consult Notes, Command Health, X, MD, X
ODG: X(online); "Criteria, X"

PATIENT CLINICAL HISTORY SUMMARY

Patient is a X, X, who sustained a X. Patient was also noted to have a X. Initial encounter notes document X. Patient noted to have a fracture of the X, no x-ray reports available. X was placed in a cast and prescribed X.

Patient underwent nerve studies by Dr. X X. It was recommended X continue with X. It was also recommended X have a diagnostic X.

Patient underwent X by Dr. X. Patient followed up with X, NP, X; note states X had X relief and X. It was recommended X undergo another X and continue with X and follow up with Dr. X for the X. X underwent another X by Dr. X.

Patient was then seen by Dr. X. X impression was X with X pain, X pain syndrome, and stiffness in X X. Dr. X recommended X with superficial X, with possible X of the X.

PATIENT CLINICAL HISTORY SUMMARY (continuation)
Dr. X note from X does state that the sensation X. X was noted to have X measured from X. The note also states X had X space and X, but normal X.

X therapy records document treatment and evaluation of X X and X exercises dated X.

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

Opinion: I agree with the benefit company's decision to deny the requested service(s) for X with possible X. I also agree with the benefit company's decision to deny the request for X
Rationale: The medical records are not clear as to X sensory X and I do not feel that X is medically necessary.

I also feel that the patient has not received sufficient therapy for X, only 4 visits have been documented over a 3 week period of time.

The requested services listed in above opinion are not medically necessary.

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

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

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 DESCRIPTION)

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