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IRO Certificate #XX

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Letter of Adverse Determination & Peer Review:X, M.D., X
Appeal Reply Letter & Peer Review:X, M.D., X
Referrals for Rehabilitation Svcs (3): X
TX Compensation Work Status Report (3): X
Clinical (office) Notes: X Orthopedic & Sports Medicine Clinic, X, M.D.,X; X Occupational Medicine Clinic, X, PA-C, X
Follow-up Note (1): X Rehabilitation Center, X, M.D., XX
ODG: *"Pain Chapter" (updated 5/10/19)*

PATIENT CLINICAL HISTORY SUMMARY

This is a X year old X who sustained a work related injury in X, when X bumped X. On X X saw Dr. X, complained of pain in the X, received a greater X. On X X was seen at the X Occupational Medicine Clinic by X, PA, who noted most of X pain in X. Diagnosis included X, X. Follow up note from X rehabilitation center on X reported X had no improvement from another X by Dr. X. X continues to have pain in the X area, X, and X was scheduled for an X study next day. Assessment was X. Recommendation for more X and possible X block. EMG report from X shows normal EMG of the X. Note from Dr. X on X shows that X did not help. Referral for X placed. There is mention of X diagnosis in that note. On X X was ordered for X. On X patient was seen at the X Occupational Medicine Clinic by X, PA, who reported that X pain is in the X. There is X sensation. It is improved with X. Physical examination documented X to pain sensation and X, pain to X. Documented X ER visits, X with no benefit. Unable to take X due to allergy. X had XX testing at X XX XX only positive for

PATIENT CLINICAL HISTORY SUMMARY (continuation)

X pain from injury that disturbs X activity of daily living. Patient reported in the past of not being able to wear X due to increase in pain but was X office visit. Patient was continued on X and X. Diagnosis included X. Pain level was reported as X. On X physical therapy was ordered for 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.

Rationale: The review pertains to the need for additional X after completing some unknown number of sessions of X. ODG cited was for X. Number of X visits completed to date is unknown. There are several diagnoses mentioned in clinical notes including X. MRI results are not known. EMG result was normal. There is no documentation of previous X for the current injury. There is not enough information to disagree with the benefit company's decision to deny the requested service. The requested service is not medically necessary for this patient.

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)