Parker Healthcare Management Organization, Inc.
3719 N. Beltline Rd Irving, TX 75038
972.906.0603 972.906.0615 (fax)
IRO Cert#XX

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-55 pages

Respondent records- a total of 81 pages of records received to include but not limited to:
TDI Letter X; Request for IRO forms; X letter X; Peer Review Report
X; X, MD Appeal Letter X; X, MD Records X; X
Imaging report X

Requestor records- a total of 27 pages of records received to include but not limited to:
X Request for Records; X letter X; Peer Review Report X,
X; X, MD Appeal Letter X; X, MD Records X-
X; X Imaging report X

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PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a X who was injured on X, in a mechanism that was not denoted. The claimant was diagnosed with X pain, X. An X was performed on X, status X. An evaluation on X, documented X pain, X greater than X. There was also X. The claimant performed a X exercise program on a daily basis. There was an X favoring the X with continued use of X. There was X testing on the X degrees, X in the XX X distribution with tenderness over the X, and tenderness over the X. Forward flexion was X degrees and extension was 0 degrees. The X studies in X suggested X. The EMG was normal. The claimant has failed X

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

The previous noncertification on X, was due to findings of X symptoms on physical examination without documentation of a prior X with positive outcome. The previous noncertification is supported. Additional records included an appeal letter on X, documented there were original X on X, with pain relief for one day. There is no documentation of X pain relief after the previous X. This procedure is limited to those with X pain. The claimant has radicular symptoms with X with use of an X. Electrodiagnostic studies suggested X. There was no notation of lower levels of care such as use of X. Therefore, medical necessity for the X was not established. The denial is X.

Official Disability Guidelines X (updated X) Recommended for primary treatment when a diagnostic X is positive, using criteria below. Repeat treatment is recommended following the same criteria on a case-by-case basis. Available research is contradictory regarding X, with no demonstration of improved function. This procedure, also referred to as X, X, creates a heat lesion on specific nerves, attempting to interrupt pain signals to the brain. X specifically affects nerves carrying pain from the X. See X; X (X); and X (blocks). Criteria for use of X: (1) Treatment requires a solid diagnosis of X confirmed by a X with a response of ≥70% for the duration of the X. (2) This procedure is limited only to patients with X pain. (3) There is documentation of failure of conservative treatment (including X) prior to the procedure. (4) While repeat X may be required, they should not be performed at intervals of < X. Duration of effect after the first procedure should be documented for >X relief. Current literature does not support procedural success without sustained pain relief of at least X months duration; therefore, more than X procedures should never be performed within X months. (5) Approval of repeat neurotomies depends on variables such as evidence of adequate X, documented improvement in X, decreased medications and documented improvement in function. (6) No more than X are to be performed at one time. (7) If different regions require neural blockade, these should be performed at intervals of no sooner than X, and preferably X weeks for most X . (8) There should be evidence of a formal plan of additional evidence-based conservative care in addition to X.

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

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

XX 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)