MedHealth **R**eview, **I**nc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: X.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from X: X denial letter, X denial letter, X preauth request, office notes by Dr. X to X, X MRI report X, X X Neurology neurodiagnostic report, progress notes, POC, and exams from X PT X to X, X to X office notes from X, X preauth request, and X approval letter.

Dr.X : DWC 73 XX, notes from X XX Department X, and X approval letter.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a X who sustained an industrial injury on X. The mechanism of injury was described as a X. The X EMG/NCV report impression documented X; i.e. X. Clinically, there was evidence of X. There was no evidence of X, X, or more X. Records documented that the patient had

been approved for X on X but this was delayed as X was unable to take any more time off until X. A review of the orthopedic visit notes from X through X indicated that the patient was under treatment for X. Conservative treatment to include X, X, X, X, X, and X. The X orthopedic progress notes indicated that the patient was seen in follow-up for X. X reported the X helped some, but for a short period of time. Pain had been progressive for the last X to X weeks. X reported associated X but was not X. X reported some improvement with X, but nothing completely resolves the pain. X reported X with associated X in X. Physical exam documented tenderness present over X. Neurologic exam documented X present in all distributions, X strength, and no X signs present over the X. The diagnosis included X, X, and X. The treatment plan recommended a X and X for a X days. The X orthopedic progress notes cited complaints of continued severe X pain as well as X in X. X reported an X while X at work recently requiring an emergency room visit due to severe pain. X reported pain outside X with X, grade X. X had failed conservative management including. X was ready for surgery and could no longer function. Physical exam documented tenderness present over both X. Neurologic exam documented X present in all distributions, X strength, and no X signs present over the X. The diagnosis included X. The treatment plan recommended X X release, X with X, same on the X. Authorization was requested on X for open X, X, and X week post-op X. The X utilization review non-certified the request for X, and X-week post-op X. The rationale stated that there were minimal exam findings to substantiate the request for X, no electrodiagnostic evidence of X, and only X syndrome on electrodiagnostic studies. The X utilization review non-certified the appeal request for X, X, and X-week post-op X. The rationale stated that there was a lack of objective findings to support the requested X, and a lack of documented exhausted forms of conservative

treatment and no documented findings to support the request for X.

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

The Official Disability Guidelines recommends surgery for X(X) when specific indications have been met. Surgical indications include failure of at least X months of initial conservative care unless clearly documented acute or advanced findings of X, X. Surgical indications include pain, functional difficulty and sensory deficit involving the X with abnormalities on nerve conduction study consistent with X.

The Official Disability Guidelines recommend X surgery only with an X. For non-X, surgical indications include: Symptoms (X) requiring two of the following: abnormal X scores, X, and X sign; Physical exam requiring two of the following: X test, X test, X sign, X sign, decreased 2 X , and mild X; Initial conservative treatment requiring three of the following: activity modification, X , non-prescription X, and X; Successful initial XX injection trial; and, Positive electrodiagnostic testing for X for documented non-classic X.

This patient presents with complaints of X pain with X. Functional limitations are noted in activities of daily living and work ability. Records indicate that the patient has been diagnosed X. There is electrodiagnostic evidence of mild X syndrome. Detailed evidence of a recent, reasonable and/or X non-operative treatment protocol trial for the diagnoses of X and failure has been submitted. Under consideration is a request for X four weeks after the X. The Official Disability Guidelines criteria have not been met for this request. Relative to the X, there is no current documentation of abnormal X diagram scores, X, and/or X sign. There is no

current clinical evidence of limited sensation in the X distribution, X testing, decreased sensation, and/or thenar weakness. Relative to the X, there is no documentation of pain, functional difficulty and sensory deficit involving the X. There are no objective clinical findings of X with abnormalities on nerve conduction study consistent with X. There is no documentation of a trial of conservative treatment for X. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception to guidelines. Therefore, this request for X, X four weeks after the X is not medically necessary.

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**

☐ **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)**