AccuReview
An Independent Review Organization
569 TM West Parkway
West, TX 76691
Phone (254) 640-1738
Fax (888) 492-8305

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X: MRI X
X: Office Visit by X, DO
X: X MRI
X : Office Visit by X, DO
X: Office Visit by X, DO
X: Office Visit by X, DO
X: Physical Therapy Evaluation/Reevaluation by X, PT
X: UR performed by X, MD
X: UR performed by X, MD
X: Office Visit by X, DO

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a X year old X who was injured on X when X was at work X. The X with X X and pulled X X. According to records, the claimant underwent X. The first round consisted of X, the X being on X. X X concluded with the X.

On X, MRI X: 1. X image X. 2. X. 3. X. 4. X XX. 5. X or significant X and while this may represent early X to exclude recent trauma. 6. X.

On X, the claimant presented to X, DO for initial evaluation of X X pain. Pain was described X. ROM was full but painful. Treatment to date included 3 X. Plan: MRI to evaluate progression of X. Continue with medications and activity modification.

On X, X MRI Impression: 1. There are no partial X. There is moderate X. 2.X. 3.X. There is a calcified focus centrally within this X and there is X of the X. An

X can have this appearance. Correlate for any pain at night and/or pain relieved with X. 4. X.

On X, the claimant presented to X, DO following the MRI. No change in symptoms or physical exam. Plan: X, X and associated procedures.

On X, the claimant presented to X, DO. On exam there was tenderness present at the X, and X. ROM was with pain. Strength was X. Positive empty cans test caused X. X test positive flexion to X degrees, internal rotation caused pain. X Test. X test was positive and caused pain. X test was positive. X test was positive. Negative X test, X Sign. Plan: Still recommending surgery, in the interim, continue physical therapy and modify activity as needed.

On X, the claimant presented to X, PT for a X evaluation. It was noted that prior treatment included X rounds of X. Impression: Signs and symptoms are consistent X, as well as X, possibly caused by mass noted on MRI in X. Plan: Patient will be seen X times per week x X weeks for a total of X visits.

On X, X, MD performed a UR. Rational for Denial: The guidelines recommend physical therapy medical treatment for X at X visits over X weeks. The patient presented with X pain rated at X which was X. The patient had X rounds of X previously. It was noted that the patient was a good candidate to benefit from X and had a good prognosis with a high likelihood to reach functional goals and return to the previous level of function. A request for X sessions of X for the X was made; however, the number of completed X visits to date could not be identified in the records to note whether or not the request exceeds the recommended number of visits. A clear and quantifiable objective comparison could not be fully established to validate efficacy from prior sessions and warrant additional sessions. Clarification is needed regarding the request and how it might change the treatment recommendations as well as the patient's clinical outcomes.

On X, X, MD performed a UR. Rationale for Denial: The number of completed X visits to date could still not be identified in the records to note whether or not the request exceeded the recommended number of visits. There are no co-morbid conditions that suggest a medical explanation for the delay in

recovery. Continuation of X sessions alone is no longer supported with this information and lack of exceptions to support continuation.

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

The request for X is not medically necessary. This claimant injured X in X. The X MRI of the X identified a X. The second MRI (X) revealed X, without evidence of a X. The claimant remains X. X has completed X rounds of X(X), X, and medication. In the X office note, X has X strength and a X sign. The treating provider has recommended additional X for X.

The Official Disability Guidelines (ODG) supports physical therapy for X injuries. X sessions over X weeks are recommended for X syndrome. X over X weeks are appropriate for a X. The additional X sessions exceeds the recommendations of the ODG for the treatment of this X injury. Continued X is not medically necessary for this claimant.

PER ODG:

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)