**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**
Records were received and reviewed from the following parties: X Health Care and X Medicine /X, MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from X Health Care:
X Health Care:
- Denial Letters-X
- Utilization Review Referral Form-X

X Medicine /X, MD:
- Order Forms-X
- Office Visit Notes-X

X Physicians:
- Office Visit Notes-X
- Lab Requisition-X

X Healthcare:
- MRI Report-X
- WC Authorization Request Form-X
- Plan of Care-X

Records reviewed from X Medicine /X, MD:
X Medicine /X, MD:
- New Patient History-X
- Follow-up Visit Notes-X

X, MD:
- MRI Report-X

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 year-old X who sustained an X injury on X. Injury occurred when X was X, and X was X on X X X which caused sharp pain. The X X X MRI impression documented unchanged X and X along the X of the XX, and decrease in X. There was no significant change in small areas of X in the X, X, and X zone. Findings documented a X with X at the X of the X area of full thickness XX loss and minimal X at the X of the X. The X orthopedic report indicated that the patient was still going to X, doing a X program, and wearing a X XX. X was unable to stand for more than X at a time without much pain. Current medications included X. X X exam documented X, X or X. There was tenderness to palpation over the X, and X, and X. Range of motion documented active X with pain and passive X with pain, no restriction in X, and pain with X.

There was no instability on exam. There was pain with attempted X and with X. MRI was reviewed and showed an unchanged X and X, and X X. The treatment plan recommended continued X and X. The patient was referred to X for consideration of X to decrease pain and increase function. The X pain management report cited complaints of constant X X pain described as X, X, and X, and X. Pain was rated grade X with medications and grade X without medications. X was undergoing X with some improvement. Pain was worse with X, and better with X. Pain affected X quality of life and decreased functioning. Physical exam documented X, decreased X, and use of X. X X was in a X that was easily doffed. X X exam documented pain with X. There was tenderness over the X, but tenderness was most severe over the X,X. There was X X X X and X, X, and X, and X. X strength was documented as X. X was unable to X without difficulty. A X X diagnostic ultrasound was performed and showed *a X* deposit at the X attachment at the X. The diagnosis included X of the X X and X. The treatment plan recommended a X of the X deposit. A X l pain X was prescribed. The X peer review report indicated that the request for X of the X X was denied. The rationale stated that X was not recommended by evidence based medical guidelines since this treatment remained unproven. The X pain management report indicated that the patient had persistent X X pain. X was doing regular X and taking X. Pain was grade X with medications and grade X without medications. X X exam was unchanged from X. The treatment plan recommended a X deposit to help heal the X with the X deposit that was present. A X was prescribed. The X peer review report indicated that the request for X of the X X was denied. The rationale indicated that there were no high-quality studies to warrant the need for this request based on controlled trials, and exceptional factors were not established to warrant the use of this non-recommended treatment. The X pain management report cited complaints of persistent X X pain. X was doing regular X and taking X. It was noted that X X had been denied a third time. Physical exam findings were unchanged from X. It was noted that the patient would benefit from a X to help heal the X with the X deposit that was present. X was to see the orthopedic surgeon for consideration of an open X. The treatment plan recommended initiation of X every X hours as needed.

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

This patient presents with persistent X X pain and global X X weakness. X are noted in X activities. Clinical exam findings have been reported consistent with X with MRI evidence of a X along the X of the X, and diagnostic ultrasound evidence of a X at the X at the X. Under consideration is a request for X. Evidence based medical guidelines do not recommend this procedure based on a lack of high-quality studies. 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 of X is not medically necessary.

The Official Disability Guidelines state that X is not recommended since this treatment remained unproven. Guidelines state that further well-designed studies are needed to explore the effects of this controversial treatment. Evidence based medical guidelines do not recommend this procedure based on a lack of high-quality studies. 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 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**
- ☐ **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)**