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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

TDI:

- Utilization review (X)
- Correspondence (X)
- Reconsideration (X)

XX (1)

- Diagnostic (X)
- Office visit (X)
- DDE (X)
- Prior authorization request (X)
- Utilization review (X)
- Correspondence (X)

XX

- Diagnostic (X)
- PT notes (X)
- Office visits (X)
- MMI/IR evaluation (X)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X-year-old X who was injured on X. X was X X was X X back and felt X in X.

On X, a magnetic resonance imaging (MRI) of the X from X Imaging was interpreted by X, M.D. The indication of the study was X. The study showed X and X slightly displacing the X. The X with X was noted. At X, there was X and X. At X, there was X.

From X, through X, the patient attended three physical therapy (PT) sessions at XX XX Therapy with modalities consisting of therapeutic exercises.

On X, X, M.D., evaluated the patient for continued X. The patient reported X was X and boxes and X X when X felt X. X described the pain as X. X also experienced X in X but worse on the X. The pain was worsened when X. The diagnoses were X (X) of X X in the X was pending. The patient was referred to X for further injection and medication management. The patient was placed off X

On X, X, M.D., performed X.

On X, Dr. X saw the patient for continued X. The patient reported some improvement with the recent X. However, the X pain was constant and rated a X. The pain radiated into X, causing severe pain. The pain was aggravated with X, and relieved with X and X medications and X treatment. X also had X pain, rated at 6/10 and 7/10 was intermittent. The pain radiated into the X more than the X along with occasional X. The X examination showed X and decreased X to pain. X were noted. The X examination showed increased X. X was noted. Mildly reduced X was evident. X test was X. Palpation over the X was mildly/moderately tender in X regions. X test was positive. The diagnoses were X pain. X and X were prescribed and X and X were recommended.

On X, X, D.C., performed a maximum medical improvement/impairment rating (MMI/IR) evaluation. The accepted diagnosis by the insurance carrier was X. Dr. X opined that the patient had reached clinical MMI on X with X.

On X, Dr. X examined the patient for a medication refill. The patient reported X pain as X and X and was constant. The pain was X. The pain was shooting down to the X more than the X along with occasional X. The pain was aggravated with X. X also reported X. The X examination showed X X was noted. X were noted. The X had increased X. X tenderness and mildly reduced ROM was noted. X was noted. The X tone was increased. X test was positive The X. There was a painful X. The diagnoses were X, X, X. X and X were continued. A X and X and X were recommended.

On X, X, D.C., performed Designated Doctor's Examination (DDE). Dr. X opined that as per certification 1: The accepted injury was only the X. The patient had not reached X and expected and anticipated the date of X would be X. Per Certification 2: The accepted injury was X. The disputed injury was X. The patient had not reached X and expected and anticipated X date would be X, for all the accepted injuries plus all disputed injuries included X. Dr. X opined that the patient's clinical findings consistently been shown to contain X and an MRI dated X, which revealed an X with pressure on the X. Dr. X opined that the diagnoses of X should reasonably and markedly improve with additional treatment.

On X, a prior authorization request by Dr. X was completed for the X

Per Utilization Review dated X, by X, M.D., the request for X and x was denied. Rationale: "*Based on the clinical information provided, the request for X, outpatient is recommended as medically necessary. Office visit dated X, indicated that the patient reports that X pain does not X. The patient reportedly underwent a recent designated doctor evaluation. However, the report is not submitted for review. While the submitted X documents X, there is no documentation of X. Medical*

necessity is not established in accordance with current evidence based guidelines."

On X, correspondence from X indicated Dr. X was notified about the denial.

On X, the patient was seen by Dr. X for a X. The patient reported minimal improvement with the X. But in all medical probability, during X accident when X twisted X, the injury could have extended to the X and caused damage leaving X. The plan was to continue X, X and start X was continued.

Per Reconsideration dated X, by X, D.C., the request for X as outpatient between X, and X, be non-certified. Rationale: "*The claimant is a X year-old X with a date of injury of X. The documentation includes a designated doctor report from Dr. X and dated X. The report provides an updated work history indicating the claimant is X as X. X states X is still working for the X but is X the X. X is complaining of X pain, X, and pain X. X is complaining of pain levels of X. Dr. X makes a note of the X, X, which notes that there is a X, which slightly displaces the X discussed but not significant X. Dr. X does not feel that the claimant has reached X and feels that the claimant has X decreased X. X. These findings are not consistent with the MRI. The patient is also evaluated by pain management specialist X, M.D., on X. Dr. X notes that the patient states X is having X pain. The claimant also reported that X does not have any X. The examination by Dr. X notes that muscle strength is X. Also notes that the sensation to X Xl regions. X notes that X X are normal and that X is positive X but does not indicate what the X produces, whether it is X pain or X. X does note that the femoral stretch test, however, is negative bilaterally. In summary, there is a possible need for a X. However, there is no indication noted on physical examination by Dr. X for the medical necessity of a X. Therefore, since I am unable to speak to Dr. X, the request for X is not medically necessary and cannot be altered to Just the X*."

Per a correspondence dated X, Dr. X was noticed about the denial from X.

On X, Dr. X saw the patient for a X. The X examination revealed X. The X was decreased X to pain. X were noted at the X. The X had increased X. X tenderness and mildly reduced ROM was noted at the X. X was noted at the X. The X was increased X test was positive X. The X had generalized weakness. Mild tenderness, generalized weakness and painful ROM was noted in the X. There was reduced X region. The diagnoses were X pain. X, X and X were continued. X was continued.

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

After review of the available notes, the patient has a positive X, reduced X in X, and generalized X weakness. MRI dated X: The study showed X. The X with X was noted. At X, there was X and X.

At X, there was X. The patient has X per exam. According to the ODG, the X must be X by imaging and/or X testing. There are X findings on the X. The patient has been treated with X, X, and X. The patient does not meet the criteria for a X. The requested X is not certified.

☐ Medically Necessary

X Not Medically Necessary

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**