

# **IMED, INC.**

PO Box 558 \* Melissa, TX 75454

Office: 214-223-6105 \* Fax: 469-283-2928 \* email: [imeddallas@msn.com](mailto:imeddallas@msn.com)

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

X, X, MRI of the X

X and multiple dates, X Medical Centers, clinical records of evaluation and treatment by Dr. X

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a X in the compensable event. The medical records indicate that X X X X inward while X on a X of X. X was treated with X without much improvement. X had an MRI that showed a X of the X . X is X, standing X for a BMI of X. Dr. X noted instability in the X with a positive X. X-rays showed no X. There was X and there were X.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The requested procedure is non-certified as medically necessary. The original request was denied due to lack of compliance with accepted guidelines including ODG. There are no unexplained X in the X and the diagnosis is clear from the MRI. There are no indications for a diagnostic procedure in this X.

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

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

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