

MEDRx

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IRO REVIEWER REPORT

DATE NOTICE SENT TO ALL PARTIES: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

X

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH
PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO
REVIEWED THE DECISION**

The reviewer is a Medical Doctor who is board certified in X.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X

The reviewer agrees with the previous adverse determination regarding the medical necessity of: X

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient was evaluated by X. X was noted to be a X. X has had X. On X had complained of pain in the X. X had no report of X. X had X. X had a X. X job description essential function was listed as X. X had not had any X. X was a X who already had X. A X examination by the X noted X noted; however, there was some X noted in the X. There were X noted. On X noted that it was X. They reported a X. They were X. X had a X. X would get X. The treatment provided included X. X was to progress to X. X was able to X. There were no complaints of X. X was continued. Similar records are noted on X and X. On X was complaining of X. X already had X. The X testing indicated that X had X. X also had X. On X an MRI of the X was X. On X a X was treating X for X. Treatment was provided and awaiting approval. X had begun X. X was X. On X an MRI of the X showed X. On X Dr. X ordered an X. On X an MRI of the X was reported to be X. X have been listed for X. All the 76 pages of records have been completely reviewed which include multiple visits of X.

On X a X evaluation indicated that X primary complaint appeared to be X. X also had some pain in the X. It appears that the same report is duplicated repeatedly on almost every visit at X. X reported that the X had helped X and improved X. X has had more than a sufficient number of visits with X the same elements over and over which included X. Clinical presentation does not seem to be changing on repeated visits. X has been found to have X.

The office visit of Dr. X on X has been reviewed. The doctor stated that X had used X. X had been prescribed X. On X was noted to be X pounds and X suggestive of X with a BMI of X. X were provided by Dr. X by X. The doctor gave X. X stated that X was X. The doctor was treating X unrelated X. X did not describe any X. X did not describe any X.

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

In my professional opinion, and in accordance with ODG guidelines, the request for X is not medically necessary. Based on the medical record review I do not find X. The medical literature including the ODG guidelines do not recommend such interventions in an X month old injury. The single episode of X has resolved. The current self-reported X.

In conclusion, this is a X with a mechanism of injury of X. X has been diagnosed to have a X. Prior treatments have X. All the x-ray reviews also indicate that X has X. X repeated evaluations have been found to be X. The treating physician does not clearly discuss X own X. There is no clinical rationale to exceed any clear ODG guidelines to require any further treatment.

The patient is X. X has been X. The ODG X guidelines updated X state that X is not recommended after X. X has had more than X. Similarly, the ODG X guidelines updated X recommends X. The ODG X guidelines updated on X recommends X. Similarly, the ODG X guidelines recommend X. Therefore, the request for 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
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)