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An Independent Review Organization
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Description of the service or services in dispute:
Purchase of XX XX for the XX XX to be used following XX XX.
XX - XX XX, semi-rigid, XX XX, two piece with XX extension, XX, off-the-shelf

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified Orthopedic Surgeon

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

	Overturned	(Disagree)
☑	Upheld	(Agree)
☐	Partially Overturned	(Agree in part / Disagree in part)

Patient Clinical History (Summary)
XXXX who was diagnosed with other XX XX of XX region (XX.XX). XXXX. The additional diagnoses were XX pain, XX XX, XX XX strain, and XX strain / XX XX.

XXXX had an Impairment Evaluation by XXXX. The purpose of evaluation was to determine the extent of injury; based on that extent of injury, had XXXX reached maximum medical improvement, and if so, was any appropriate impairment assessed. XXXX opined that within a reasonable medical probability, the work-related accident caused the XX XX and XX XX XX at XX-XX and XX-XX. XXXX found that the compensable injury of XXXX was a substantial factor in bringing about the XX XX caused by the XX XX at XX-XX and XX-XX, and without the XXXX injury, those conditions would not have occurred. Specifically, the injury did not extend to include XX XX and XX XX XX at XX-XX and XX-XX. XXXX also stated that when the XX% for the XX XX was combined with the XX% for the XX XX, that yielded a total Whole Person Impairment Rating of XX%. In the injuries were limited XX XX strain, XX strain and XX XX not associated with XX-XX and XX-XX, XXXX found XX% Whole Person Impairment was appropriate.

On XXXX, XXXX was evaluated by XXXX for the follow-up of XX pain and XX XX pain. XXXX reported worsening of symptoms. The pain was XX type of pain rated as XX/10. XXXX had a recent work-related fall on XXXX. The symptoms were aggravated by XX flexion, extension, rotation; prolonged sitting; lifting, and activity, and alleviated by rest. On examination, there was moderate limitation of XX XX

range of motion secondary to pain. XXXX recommended that XXXX continue off work with no activities for XX and continue the medications.

Electromyography / nerve conduction velocity report dated XXXX revealed normal electromyography of the XX XX XX. No electrodiagnostic findings were noted for a XX XX or XX XX.

An MRI of the XX XX dated XXXX revealed moderate-to-marked secondary XX XX XX XX at XX-XX and XX-XX. Moderate secondary central canal XX XX at XX-XX was noted. Mild secondary XX XX XX XX was seen at XX-XX. There was XX XX XX at XX-XX, XX-XX, and XX-XX. There was moderate XX XX XX at the XX-XX level.

Treatment to date included medications XXXX XX therapy (XXXX), epidural XX injection, and modified duty without significant benefit.

Per a peer review report dated XXXX recommended noncertification of the request for XX-XX XX XX discectomy and fusion as not medically necessary. While there was moderate / XX XX XX at XX-XX and XX-XX, there was insufficient history suggestive of a XX XX and no documented examination findings of a XX to suggest that XXXX was XX such that surgery was indicated.

In a peer review dated XXXX denied the request for purchase of XX XX for the XX XX to be used following XX fusion. In conjunction to the utilization review, there was also a review completed regarding the medical necessity of the XX-XX XX XX XX and XX, which was determined to be not medically necessary. Given noncertification of the requested surgical procedure, medical necessity of postoperative purchase of a XX XX for the XX XX was not indicated; therefore, the request was noncertified. XXXX also recommended noncertifying the requested purchase of XX XX XX for the XX XX to be used following XX fusion. In conjunction to the utilization review, there was also a review completed regarding the medical necessity of the XX-XX XX XX XX and XX, which was determined to be not medically necessary. Given non-certification of the requested surgical procedure, medical necessity of a XX purchase XX for the XX XX to be used following XX XX was not indicated. Therefore, the request was noncertified.

Per utilization review determination letter dated XXXX the request for purchase of XX XX for the XX XX to be used following XX XX was noncertified. In conjunction to the utilization review, there was also a review completed regarding the medical necessity for the XX-XX XX XX XX and XX, which was deemed to be not medically necessary. Given noncertification of the requested surgical procedure, medical necessity of a XX XX of XX XX for the XX XX was not indicated; therefore, the request was noncertified.

On XXXX completed a peer review and recommended that the request for XX-XX XX XX XX and XX, purchase of XX XX, and purchase of XX for the XX XX following XX fusion be noncertified. It was determined that XXXX reported pain in the XX that radiated down the XX XX and was rated as an XX/10 on the pain scale. XXXX had XX therapy and an epidural steroid injection with no significant benefit. Objective findings included limited XX range of motion secondary to pain. It was noted that there was no clear objective documentation of neurological deficits in the XX through XX distributions indicative of XX. Therefore, the request for XX-XX XX XX XX and XX was noncertified. Given that the request for XX-XX XX XX XX and XX had been recommended for noncertification, the request for XX XX for the XX XX to be used following XX fusion, as well as the request for purchase of XX for the XX XX were noncertified.

A reconsideration review decision letter dated XXXX, documented that the appeal for reconsideration of the purchase of XX XX for the XX XX to be used following XX XX had been reviewed and the original noncertification determination upheld. Rationale: "Given that the request for XX-XX XX XX XX and XX has been recommended for noncertification, I am recommending noncertifying the request for XX XX for the XX XX to be used following XX fusion."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The concurrent surgical request for this claimant is recommended as reasonable and medically necessary. Therefore, the use of a XX XX post-operative after a two level XX would be appropriate in order to protect the XX construct while it heals. As such, it is this reviewer's opinion that medical necessity is established and the prior denials are overturned.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low XX Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance

Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.