US Decisions Inc.

An Independent Review Organization
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Description of the service or services in dispute:
XX.

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified PMR and Pain Managment

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. XXXX was diagnosed with XX XX pain, XX and XX region, and post-XX syndrome.

XXXX. XXXX complained of XX greater than XX XX pain, which was XX in nature. XXXX admitted to mild discomfort, which radiated to the XX area. XXXX denied any XX extremity numbness, tingling, weakness or XX / XX changes. XXXX symptoms were primarily aggravated with standing XX, and twisting at the XX. XXXX symptoms improved with lying flat and taking medications for pain. XX examination showed decreased XX / extension. The pain increased with XX / extension. XX and XX test were XX XX. Muscle strength in the XX extremities was XX/5. Sensation was decreased XX in the XX leg. The gait was XX. XXXX used a single-XX for ambulation.

An XX dated XXXX showed mild-to-moderate XX height at XX. There were XX changes from a XX-sided XX at that level. There was prominent enhancing soft tissue surrounding the XX XX, more evident to the XX line and surrounding the XX root. No residual or recurrent XX or XX effect on XX roots was apparent. There was no XX or XX. A XX was noted at XX and XX. No XX was seen at those levels and no significant XX. The XX and XX were unremarkable. There was XX

A XX dated XXXX showed a XXl with XX resulting in moderate XX and XX and XX. There was XX and XX at the remaining levels. A partially-visualized XX was seen.

The treatment to date included XX surgery in XXXX, XX implant in XXXX, XX XX of XX therapy in XXXX, XX radiofrequency XX on XXXX (greater than XX% relief for XX years), XX XX on XXXX (XX% relief for XX months) and XXXX (XX% relief for XX weeks), and medications (XXXX).

Per an Adverse Determination letter dated XXXX, the request for XX at XX and XX was denied. Rationale: The proposed treatment consisting of XX and XX was not medically necessary. ODG Guidelines support the utilization of XX for patients with demonstrated benefit of at least XX% for more than XX weeks from prior XX following positive diagnostic block. In this case, the claimant received benefit from prior XX; however, "evidence of adequate diagnostic XX, documented improvement in visual XX XX, decreased medications and documented improvement in function" is not indicated. Therefore, the proposed treatment consisting of XX and XX is not medically necessary.

Per an Appeal Letter by XXXX dated XXXX, based on XXXX history, imaging and physical examination, XXXX would be an ideal candidate for repeating XX and XX XX to improve XXXX XX XX joint XX. XXXX was status post XX XX XX on XXXX that had given XXXX greater than XX% pain relief and functional improvement for XXXX years. XXXX also had completed XX of the XX area at XX and XX XX on XXXX that had given XXXX greater than XX% relief for one week. Due to this improvement, XXXX had discontinued XX medications after XXXX XX and was currently managing XXXX pain symptoms with XXXX on as-needed basis for spasms.

Per an Adverse Determination letter dated XXXX, the request for XX and XX was denied. Rationale: The proposed treatment consisting of XX and XX was not appropriate and medically necessary for the diagnosis and clinical findings. According to the reviewer, with positive objective XX XX findings still present, that was a contraindication for doing XX based on the guideline criteria. Therefore, the request was non-certified.

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

The provided records would not support the XX XX request was medically necessary. The claimant's prior XX XX was XXXX. While there was a prior positive response to XX XX, given the interval time period between the claimant's current evaluation and the last XX XX, confirmatory diagnostic blocks would be appropriate at this point to confirm pain generators. Therefore, in this reviewer's opinion medical necessity is not established.

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 Back 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.