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Information Provided to the IRO for Review

- Peer Review – X
- Diagnostic Date – X
- Clinical Records – X
- Physical Therapy Note – X
- Utilization Review – X
- Notifications of Adverse Determination – X
- Notification of Reconsideration Adverse Determination – X

Patient Clinical History (Summary)

X who was injured on X while X. The ongoing diagnoses were X, chronic pain syndrome, X, X pain, X MRI of the X, X pain, X use, repeat X issue, X status, X X, and incomplete X.

On X, X, MD saw X for evaluation of X pain and X. X presented for medication refills and to discuss further treatment options. Per the pain diagram, X had drawn on the X and had described the pain as X. X reported X pain was getting worse and stated the X pain had increased X. X could not X and had to X. X had to use X X all the time. X stated X could X on one side due to pain. X stated X had good pain relief with the X, and X done on X, but it had worn off. X reported that X had started having X and pain to X and X. X was doing X exercises regularly. X was using a X for X pain with minimal improvement. X was taking X with improvement. X rated the pain as X with medication and X without medications. On examination, the X showed positive X (as described by X) with point of maximal X region and X of pain into the X; positive X on the X degrees.

Examination of the X region showed positive pain X, X to X, positive X test / X test, X test, and X test, X severe compared to the X. X was diminished to X in the X. X was noted to be impaired. Base width of X was wider than normal and X were decreased. The X was noted to be X. X had a forward X. There was moderate X of the X and X noted.

The treatment to date included medications (X) with improvement, X, and X (good but temporary pain relief), X (minimal improvement)

A X dated X showed status post successful fluoroscopic guidance X; mild-to-moderate narrowing of the X involving X, and X status post X; and slight X. A post-X CT scan of the X dated X showed X changes without definite findings for X , fairly thin X defect along the X of the X identified especially just above the X, and significant X identified with X of both X X as noted above with X, and X identified without X of significance but with significant X and X ; X X of the X extending into the X more so the X, X with X , and probable X seen X. An MRI of the X from X showed X with moderate X and X measuring X, resulting in moderate X -based X measuring X.

Per a utilization review adverse determination letter dated X, by X, MD, the request for X, X(X) was denied. Rationale: "The request for a X procedure is not medically necessary. As noted in the ODG X Chapter X topic, such procedures are considered under study. Here, the attending provider failed to furnish a clear or compelling rationale for the decision to employ this particular treatment modality, given the conflicting evidence as to the efficacy of this procedure. The ODG further notes that approval of repeat X depends on variable such as evidence of documented improvements in function and reduction in medication consumption with prior such procedures. Here, however, the failure to return to work, and

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the fact that the claimant was deemed X on the date in question, the fact that the claimant was receiving X in addition to X, coupled with the continued reliance on X agents to include X, taken together, argued against the claimant having derived requisite improvements in function needed to justify continuation of care. Therefore, the request is not medically necessary."

Per a utilization review reconsideration adverse determination letter dated X, by X, MD, the appeal request for X branches and the X (CPT codes X) was denied. The reconsideration request had been received on X. Rationale: The request was previously denied due to the unclear evidence of X for this treatment as well as the lack of improvement in function and decrease in medication consumption. The Official Disability Guideline discusses indications for X. This treatment may be indicated in situations where a patient has a clinical history suggestive of X pain, partially characterized by X pain worse with X and without competing pain generators. In this case, the patient has multiple pain X, including a post-X, and the diagnosis of a X. A rationale or indication for X is not apparent in this situation. For these reasons, the request for appeal X, X branches and the X(X) is not medically necessary and should be non-certified."

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

Based on the clinical information provided, the request for X - Destruction by XX agent, X, with imaging guidance (fluoroscopy or CT);X, X- Destruction by XX agent, X nerve(s), with imaging guidance (fluoroscopy or CT);X, each additional X (List separately in addition to code for primary procedure) is not recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certification is upheld. Peer review dated X indicates that the patient has failed to improve despite significant invasive treatments. Further invasive treatments are not indicated. The X were not aggravated by this injury and further X are not indicated. Additionally, there are no objective measures of

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improvement following prior procedure. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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)

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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.

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