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Information Provided to the IRO for Review

- Clinical Records – X
- Utilization Reviews – X
- Attorney Letters – X
- Diagnostic Data – X

Patient Clinical History (Summary)

X with date of injury X. When X was X that was picked up by XX XX,X. The diagnoses included pain in the X.

X, MD evaluated X for a follow-up on X. X had a long history of both X pain secondary to on-the-job accident. In regard to X, X continued to have limited X. There was no X, but there was limited X secondary to X pain. X had been diagnosed with X. X had X pain and X pain which was increased with X. On examination, there was X in anterior aspect of the X. The pain increased with X. There was limited X. X had X of the X with no X identified. There was X of the X, X with no X identified. X was limited secondary to pain. X loading test was positive X. X was X.

A X screen dated X was positive for X.

An MRI of the X dated X revealed mild / early X. No large X apparent. No advanced X. Mild X of the X level related to X and X, but there was no true X at this level. No X abnormality. An MRI of the X dated X showed very mild X of the X with possible X level. Mild X at this level was noted. There was no significant X. The X was unremarkable.

The treatment to date consisted of X.

Per a utilization review dated X, X, MD non-certified the request for X. Rationale: “Based on review of the medical records provided, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Regarding the request for X, ODG guidelines state evaluation and management (E&M) outpatient visits to doctor's medical offices play a crucial role in proper diagnosis and return to function for injured workers and should generally be encouraged. Specific need for clinical office visits with a healthcare provider must always be individualized based upon review of patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. Such determination is also influenced by patient medications, since some like XX or certain XX require closer monitoring. Within the medical information available for review, there is a request for X. However, there was no documentation of why X was requested. This claimant presented with X complaints and was advised to follow up in a X from the recent office visit. Office visit is necessary to evaluate and assess this claimant’s persistence of symptoms. However, X sessions would not be reasonable as the claimant is scheduled for a X follow up. Given an inability to have a discussion with the requesting provider, to agree to modification, the currently requested X is not certified.”

Per a utilization review dated X, the request for X, date of service: X and X was non-certified by X, MD. Rationale: “. The proposed treatment consisting of X XX: X and X is not appropriate and medically necessary for this diagnosis and clinical findings. Provided documentation has objective examination findings noting X for which a follow up office visit would be recommended; however, X are excessive. Due to jurisdiction,

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request cannot be modified without attending: provider contact, As such, request for X XX: XX is not medically necessary."

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

Two prior reviews in this patient denied the request for X, stating that they were X. This patient is prescribed X on a X, and is stable from medical standpoint. The language of the guidelines with respect to X is non-specific citing that medical necessity forms the basis of the determination of need. The provider prescribes a X which requires X. The provider has also documented the X. Given the documentation available, the requested service(s) is considered medically necessary.

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

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- ☑ 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

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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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