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An Independent Review Organization
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Patient Clinical History (Summary)

X who was injured on X. X was involved in a X. X was X. X was diagnosed with other X.

X, MD evaluated X for continued X. It was associated with X. The pain was X. The pain was X. The pain level was X. It improved with X. It worsened, X. The associated symptoms were X. The X examination showed X.

On X, X was seen by X, MD for X. With regard to the X the pain was located X. The pain was X. The pain was X. X was X. The symptoms were increased with X. The pain radiated to the X. The examination revealed, X.

A X myelogram dated X showed X. A post myelogram CT of the X. It might be related to X. X caused by X were noted. There was X. There was X. There was X. An MRI of the X dated X showed X. There was X. X were noted. An MRI of the X dated X showed an X. X at X was significantly X. There was also X. X-rays of the X revealed X. An MRI of the X revealed X.

Treatment to date included medications X.

Per a Utilization Review Determination Letter dated X by X, MD, the request for X was not certified. Rationale: “Based on the clinical information submitted for this review and using the evidence-based,

peer-reviewed guidelines referenced above, this request is non-certified."

Per a Reconsideration Review Determination Letter dated X by X, MD, the request for X was denied. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is not medically necessary. In light of this presenting issues and in the absence of pertinent extenuating circumstances that would require deviation from the guidelines, the request for X is not medically necessary as the specific, limited objective response to non-interventional care prior to the consideration of the request could not be fully established in the limited records submitted."

Per a Utilization Review Determination Letter dated X by X, MD, the request for X was non-certified. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There was documentation that a psychological evaluation for the X was made, there was no actual psychological clearance report submitted that is specific for the X request. The recent office visit dated X showed X. Moreover, clear evidence of X was not fully established."

Per a Reconsideration Review Determination Letter dated X by X, MD, the request for X was denied. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is not medically necessary. In light of this presenting issues and in the absence of pertinent extenuating circumstances that would require deviation from the guidelines, the request for X is not medically necessary as there were X."

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Notice of Independent Review Decision

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

This patient presents with X. The patient has X. A X has been recommended after an extensive workup of the patient. Two prior reviews denied the request for the X. While this patient meets the diagnostic criteria for X, i.e. X, the ODG states "A X should be performed by an X. A X is recommended, with inclusion of X. It is recommended that results of this testing be provided. The procedure is not recommended in patients with X. Caution should be used in patients with documented X. The procedure should not be undertaken in any patient with a diagnosis of X." X is needed to ensure that the patient is a candidate for the X. Given the documentation available, the requested service(s) is considered not medically necessary at this time.

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
- ☐ 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.