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An Independent Review Organization
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Patient Clinical History (Summary)

X with date of injury X. X injured X as X was X. X was diagnosed with X.

X, MD evaluated X on X for X. The pain was described as X. X was doing extremely well and reported no new issues. X was taking included X. X was on additional medications which include X. X was on X. X was undergoing some X and was also being treated for a problem with X due to the X. On examination, X body mass index (BMI) was X. Neurological examination revealed X. X examination showed X. X examination was intact for normal response X. X was intact for X. The area over the X was X. There was no evidence of X. The X without incident.

An MRI of the X dated X showed status X. An MRI of the X dated X demonstrated X. A CT scan of the X showed X. There was a X. On the X, no similar changes were noted. X was in place over the X. X. A CT scan of the X dated X was negative CT of the X. An MRI of the X dated X identified X, and X, not further evaluated by MRI; no X. At X, there was X. X was maintained with X seen and X seen.

Treatment to date consisted of medications X.

Per a utilization review dated X, X, MD noncertified the request for pain X. Rationale: "The Official Disability Guidelines state that the time between X will vary based X. A programming session, which may occur along with or independent of a X, allows the clinician to adjust the patient's prescription as well as record or recall important information about the prescription.

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According to the records, the patient had an X. X denied adverse effects with the X. However, the documentation indicated that the patient's pain had only decreased from X down to X despite the use of X. There was no evidence of specific, measurable functional improvements as a result of the medications to support ongoing X. Furthermore, the patient was also prescribed additional medication for pain relief. As such, the efficacy of the patient's medication regimen is not established. Therefore, the X is non-certified."

Per a utilization review dated X, the request for X was denied by X, MD. Rationale: "The Official Disability Guidelines state that the time between X will vary based on X. The patient complained of pain in the X. The patient was doing well, and no new issues were reported. It was also noted that the X allowed the pain to be tolerable and the patient was able to continue with activities of daily living. It was also noted that without the X, the patient would require a significant amount of X. X were also consistently compliant without discrepancies. The request for the X was previously denied due to no evidence of specific, measurable functional improvements as a result of the medications to support ongoing X. There continues to be a lack of documentation regarding a significant quantified decrease in pain score with the usage of the X. There was also a lack of documentation regarding objective functional improvements. As such, the request for X is non-certified. Peer to peer contact was unsuccessful."

An undated letter by X, X indicated that they recently received a denial notification for an X on the basis that documentation indicated X pain only decreased from X down to a X despite the multiple use of X. X did not use X, X utilized X which was a nerve pain medication used specifically for X. The denial letter also indicated that there was no evidence of specific measurable functional improvements as a result of the medications to support ongoing X, and that X was also prescribed additional medications for pain relief. Once more, X only took X and had mentioned multiple times that without the use of X, X pain would be intolerable, and X would not be

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able to continue with activities of daily living. X also had a history of X, which was understandably not compensable to X initial injury; however, without the use of X diagnosis along with initial pain diagnosis would require a significant amount of oral medications to sustain X chronic pain. X screens had been consistently compliant and without discrepancies. X believed a X of X was medically necessary given the relief obtained with this treatment modality.

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

Official Disability Guidelines discusses X. Such a X may be indicated in situations where a patient has failed all other first-line options. The patient has already had such X and reports significant benefit from this treatment. Continuation would be supported at this time. 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
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- 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

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- 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.