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Information Provided to the IRO for Review:

- Clinical Records –X
- Physical Therapy Notes – X
- Utilization Review Decision Letter – X
- Texas Workers' Compensation Work Status Report – X
- Worker's Comp. Appeal Request – X
- Adverse Determination Letter – X
- Diagnostic Data – X

Patient Clinical History (Summary)

X is a X-year-old X who was injured on X when X X. X was diagnosed with other XX.

X. X was evaluated by X, DO on X for a follow-up of X pain since the original X injury, where X X at work back in X. The quality of the pain was described as X, occasional and without any change. Associated symptoms included X. Alleviating factors included X. The pain was X. X was status X on X. X reported minimal temporary relief after the X, and X continued to have pain. X continued to use a X as needed. X stated nothing X X symptoms. X would like to proceed with X solution. On examination, X had an X. There was X. The X was painful with limited X. There was pain about the X

X. Forced X sign reproduced symptoms. X. X was evaluated by Dr. XX on X. On X, X presented for a follow-up of X pain since X injury. The quality of pain was described as X, occasional, and unchanged. The symptoms were associated with X. Alleviating factors included X). X stated the aggravating factors were X. X continued with the X as needed. On examination, X body mass index (BMI) was X. X was found to have an X. The swelling about the X was slightly better. X had painful X of the X, which was minimally improved. The muscle strength was X, X. There was improvement in the painful X. The pain about the X, about the X, about the X had minimally improved. Forced X sign was positive. Dr. X recommended X. On X, X. X continued to have pain related to X. The plan was to proceed with X.

An MRI of the X dated X showed X, likely due to prior chronic X.

The treatment to date included medications (X), X).

Per a utilization review decision letter dated X, the request for X was denied by X, MD. Rationale: “Per evidence-based guidelines, surgery is recommended for patients with pertinent subjective and objective clinical findings corroborated by imaging studies after the provision of conservative treatments. MRI of the X due to prior chronic X with a minimal fluid within the X. However, the objective clinical findings presented as well as functional limitations were limited to indicate significant pathology to fully support the current requested procedure. Moreover, there was no positive stress x-rays submitted, which identify motion at the X. In addition, there is insufficient evidence to support or refute benefits of X as per state guidelines. Clarification is needed regarding the request and how it might affect the patient's clinical outcomes. Exceptional factors were not present.”

On X, Dr. X made an appeal in regard to the X.

Per an adverse determination letter dated X, the prior denial was upheld by X, MD with the following rationale: “Per evidence-based guidelines, surgery is recommended for patients with pertinent subjective and objective clinical findings corroborated by imaging studies after the provision of conservative treatments. In this case, the patient presented with X pain. MRI of the X done on X revealed X were intact. There was X due to prior chronic X. There was a minimal fluid within the X. An appeal request for X was made. However, XX with XX XX or X as part of conservative measures were thoroughly documented from the medicals submitted prior considering this procedure. Also, subjective and objective clinical findings were still limited to warrant the need for this procedure. Moreover, exceptional factors that would allow the request to deviate from guideline recommendations were not established.
Furthermore, I spoke to Dr. X, who stated that the patient had X, which helped briefly. The patient has not had X, as the provider did not feel that it would be helpful for X. The patient has had a X, as well as X and activity modification. The patient does not fully meet the criteria per Official Disability Guidelines (ODG). There has not been exhaustion of conservative measures including X immobilization for three-four weeks. The patient does have signs of X as well as inflammatory changes about the X on MRI. Formal immobilization would definitely provide appropriate rest, potential healing, and may alleviate the need for further invasive procedure. Therefore, the request is not supported.”

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

The ODG does not have a specific recommendation regarding X for the treatment of X. Guidelines indicate that X can be utilized for the treatment of X. Current medical literature supports X for the treatment of X following a failure of conservative management. Conservative care includes X. The documentation provided indicates

that the injured worker has ongoing planes of X pain following an injury which have not improved despite X. A physical exam documented an X sign. The provider indicated that the injured worker has ongoing pain related to X and has recommended an X of the X. An MRI of the X documented X due to prior X. Based on the documentation provided, current medical literature would support the requested X as there has been ongoing X pain with evidence of X on physical exam and a failure to improve with conservative care. Given the documentation available, the requested service(s) is considered medically necessary and the decision is X.

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 um knowledgebase 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 Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)