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Information Provided to the IRO for Review

- Occupational Therapy Notes – X
- Physical Therapy Note – X
- Clinical Records – X
- Appeal Letter – X
- Peer Reviews – X
- Adverse Determination Letters – X
- Letter – X

Patient Clinical History (Summary)

X is a X year-old-X who was injured on X. X got injured as a result of an X resulting in X.

In a letter dated X, X , MD documented that X. X was seen for a follow-up on X with a X , which included three x with x, x five, x, x disease, X, multiple X , X with X, X, X, and X. Dr. X opined that X. X was to benefit from an eight- to 12-week outpatient rehabilitation program to address X declined functional ability to perform XX-to-XX XX and XX XX, ongoing X for X. X needed help to XX at the time and would always need help to XX due to X X and X. X had increasing difficulty with X X was at risk for further muscle X as well as XX XX due to nature of X X injury.

On X, X. X was seen by Dr. X for a follow-up. X XX with a more X, but X was forward flexed using a X needed more assistance during X and X responded to cues to correct posture. X no longer X with wearing X. X

required assistance with ‘X in XX XX and for XX XX due to increased weakness on X. X X had almost healed and was of pin-hole size. On examination, X was sitting in a X X was X. Multiple-healed X were noted over the X. The X. XX was noted over the X-finding difficulties.

Treatment to date consisted of medications (X).

In an Adverse Determination dated X, X, MD stated that “I spoke with Dr. X regarding the request, who noted that eight weeks of therapy, three times weekly was being requested. XX noted that additional information would be faxed. At the time of the request, no additional information was received or discussed to support the request. There was no description of the patient's prior response to treatments. Occupational therapy evaluation and treatment of the X, frequency and duration unspecified, as outpatient is not medically necessary.”

In an Adverse Determination letter dated X, X, DO stated that “Based on the review of the extensive medical documentation, it is my opinion that the request for Reconsideration for X Evaluation and Treatment of the X, 8-12 weeks (frequency unspecified), as Outpatient, is not medically reasonable, necessary or appropriate. In regards to X X, there is no capability of X returning to unassisted XX. X still needs help of XX XX for even XX, and even XX XX at XX XX.”

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

This request is for X evaluation and treatment of the X. The records are unclear regarding the frequency of the proposed treatment. Moreover, the medical records do not clearly document the rationale or treatment goals proposed for this treatment. Such clinical details would be fundamental in

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order to apply treatment guidelines and evaluation of the medical necessity of this request. Therefore, based on this limited available information, at this time the request is not medically necessary and should be non-certified.

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)

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☐ 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.

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