Applied Assessments LLC

Notice of Independent Review Decision

Case Number: Date of Notice: 5/24/2019 2:31:03 PM CST

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: Clinical Records –X

- Medical Review –X
- Physical Therapy Notes –X
- Physical Therapy Discharge Summary –X
- Adverse Determination Letter –X
- Appeal Determination Denial Letter –X
- Texas Workers' Compensation Work Status Report –X
- Prospective Review Response –X
- Letter - Undated
- Diagnostic Data Report –X

PATIENT CLINICAL HISTORY [SUMMARY]: X. X is a X-year-old X-X XX with date of injury X. X was injured while X from X the X. X tried to prevent X from X and subsequently landed on his X outstretched X, causing pain to his XX. X was diagnosed with X of the X. On X, X. X was seen by X, MD for follow-up of X of the X. X reported moderate X X pain in the X, which was aching and frequent. The aggravating factors included X. X continued to have difficulties performing XX job requirements of X/ X due to pain in the X. X X examination revealed no X, X, X, X, X, or X. The X prominence was normal. X of the X revealed no tenderness of the X of the X, the X, the greater X, the X, or the X There was tenderness of the X, X on the X was limited (X). Special tests on the X including X test, X test, X test, X test, and X were negative. The X test was normal. There was no X or X sign was negative. X caused pain. X X X. X had mild prominence and tenderness directly located at the X. X had pain with X. Due to continued discomfort in the X, X had lost some of the limits of full X. Per the note, X X x -ray showed some narrowing at the X. There was X both X on the X had some X and X. An MRI of the X X X showed X with suggestion of possible small X, mild X involving the X and X with no significant X identified. There were moderate degenerative changes at the X with mild X in the X. The treatment to date included surgical intervention (X XX), X (helped a little), X, and medications (X). Per the utilization review dated X, the request for X X X and open X was denied by X, DO. Rationale: "Regarding the request for X XX X, the patient did complain of X X pain. It was also noted the patient underwent prior, however, X XX, X, X. The physical examination also revealed tenderness of the X. The patient also reported that the last injections in the X X lasted X weeks with relief. However, there was no diagnostic imaging submitted with the review. As such, the request for X X X X was noncertified." Per a utilization review dated X, the request for X X X was denied by X, MD. Rationale: "This request was previously noncertified by Dr.·X on X, as there was due to lack of diagnostic imaging submitted. No additional documentation was provided to support the request. The previous non-certification is supported. According to the guidelines, a X procedure was recommended after X weeks failed conservative treatment when there was pain at the X, tenderness to palpation over the X, and relief of pain obtained from an X. The claimant has completed greater than X weeks of failed conservative treatment to include X and multiple X of the X which did provide temporary relief of symptoms. The guidelines state that there must be evidence of X change of the X or X disease or complete or incomplete separation on diagnostic imaging. There was only one X x-ray of the X X made available for review which stated that there was limited resection of the X. The request for

Outpatient: X X X is not certified."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The ODG recommends X when there is pain at the X, tenderness over the X and/or pain relief obtained with an X of the X, imaging findings of X changes or X of the X, and a failure of the X weeks of X treatment. The provided documentation indicates persistent X X X pain despite previous treatment including X and X with X therapy, X, and X injection. It is documented that the injection provided four to X weeks of temporary relief. The treating provider has recommended open X. This request was previously denied on X separate occasions with X was a X X imaging. In the progress note from XX which occurred after the two previous reviews, the provider documents that radiographs demonstrate minimal removal of the X. This is confirmed by provided copies of x-ray images which demonstrate X between the X and the X with associated X.

Based on the provided documentation and ODG recommendation, the X X open X is medically necessary and the decision is overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR 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 & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

ODG, 2019: X