US Decisions Inc.

An Independent Review Organization
8760 A Research Blvd #512
Austin, TX 78758
Phone: (512) 782-4560
Fax: (512) 870-8452
Email: manager@us-decisions.com

Information Provided to the IRO for Review

- Clinical Records – XX
- Texas Workers' Compensation Work Status Reports – XX
- Notification of Adverse Determination – XX
- Peer Reviews – XX
- Appeal Letter – XX
- Notification of Reconsideration Adverse Determination – XX
- Diagnostic Data – XX

Patient Clinical History (Summary)

XXXX. XXXX XXXX is a XXXX-year-old, XXXX-XXXX-XXXX XXXX who sustained an injury on XXXX while lifting XX pounds at work. XXXX felt pain and a pop in XXXX XXXX. XXXX pointed to the XXXX XXXX as the area of discomfort. The diagnosis was XXXX XXXX, XXXX XXXX (XX). The associated diagnoses were pain in the XX XX (XX) and pain in the XX XXXX (XX).

XXXX. XXXX was evaluated byXX, PA-C /XX, DO on XX. On XX, XXXX presented for XX XXXX pain secondary to XXXX injury on XXXX. XXXX had a consultation with an orthopedic surgeon, and it was recommended that XXXX. XXXX would proceed with surgical intervention. XXXX had been experiencing pain for over XX months. The pain was rated at 9/10 at the time and described as achy. It was worse when XXXX used XXXX XXXX and XX. Nothing relieved it. Examination of the XX XXXX revealed tenderness to palpation over the XXXX XXXX and common extensor tendon. Resisted XX extension and radial deviation did reproduce the pain over the XXXX XXXX. The range of motion was 0-135 degrees. The strength was 5-/5. Dr. XX recommended XX XXXX XXXX resection versus repair, no lifting over XX pounds at work, and light duty only. On XX, XXXX. XXXX had a significant amount of pain over XXXX XXXX XXXX. XXXX experienced pain with any type of lifting, pushing, pulling, and opening jars. The examination of the XX XXXX remained unchanged. Dr. XX recommended continuation of a care plan including surgical intervention.

An undated x-ray of the XX XXXX showed no fractures, no dislocations, and no significant degenerative changes. The MRI of the XX XXXX dated XX showed the area of concern corresponded to approximate 25% intrasubstance partial-thickness tearing and XX involving the common extensor tendon origin. There was mild XX of the XX insertion.

The treatment to date included medications (XXXX, XXXX,XXXX),XX , XX , XX injections, activity modifications, and three months of XX l therapy. XXXX. XXXX had failed all conservative management.

Per a utilization review decision letter dated XX, the request for XX XXXX XXXX resection versus repair was denied by XXXX, MD. Rationale: "Per guidelines, surgery for XXXX is recommended for chronic XXXX or medial XXXX following 12 months of failed conservative treatment. The patient complained of XX XXXX pain. XXXX had been having pain for over XX months. XXXX had completed 3 months of physical therapy. XXXX's had XX XX injections. XXXX had pain medication, XX, XX, bracing and XXXX was still having pain. The patient has persistent symptoms and exam findings consistent with XXXX XXXX. However, 12 months of failed conservative treatment was not yet established. I made multiple attempts to contact the surgeon to garner additional information or exceptional circumstances. This was unsuccessful. Therefore, based upon the provided documentation, the request is not currently supported. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The patient has persistent symptoms and examination findings consistent with XXXX XXXX. However, 12 months of failed conservative treatment was not yet established. I made multiple attempts to contact the surgeon to garner additional information or exceptional circumstances. This was unsuccessful. Therefore, based upon the provided documentation, the request is not currently supported."

Dr. XX wrote an appeal letter on XX requesting reconsideration of the prior denial for medically necessary treatment.

Per an adverse determination letter dated XX, the prior denial was upheld by XX, MD. Rationale: "Per guidelines, surgery for XXXX is recommended for chronic XXXX or medial XXXX following 12 months of failed conservative treatment. The patient complained of XX XXXX pain. XXXX had been having pain for over XX months. XXXX had completed 3 months of physical therapy. XXXX had

Notice of Independent Review Decision

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XX injections. XXXX had pain medication, XX , XX ,XX and XXXX was still having pain. The patient has persistent symptoms and exam findings consistent with XXXX XXXX. However, 12 months of compliance with non-operative management such as XX, XXXX XX/XX, activity modification, and PT exercise programs to increase range of motion and strength of the musculature around the XXXX was still not yet established. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. 12 months of compliance with non-operative management such as nonsteroidal anti-inflammatory drugs (NSAIDs), XXXX XX / XX, activity modification, and physical therapy exercise programs to increase range of motion and strength of the musculature around the XXXX was still not yet established."

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

The ODG supports surgery for XXXX for chronic XXXX XXXX when there has been persistent symptoms that interfere with activities and a failure to improve after 12 months compliance with nonoperative management program including NSAIDs, XXXX bands/straps, activity modification, and physical therapy. The documentation provided indicates that the injured worker has had complaints of right XXXX pain 9/10 that has persisted for XX months. Previous treatment included to three months of physical therapy, XX injections, pain medication, XX , XX , and XX . A recent physical exam documented tenderness over the XXXX XXXX and common extensor tendon, pain with resisted XX extension and radial deviation, range of motion 0-135°, and -5/5 strength. An MRI of the XX XXXX documented partial-thickness tearing and XX of the common extensor XX origin. The provider indicated a diagnosis of XX XXXX XXXX and has requested a XX XXXX XXXX restriction versus repair. The previous request for surgical intervention has been denied as there was no documented trial and failure of 12 months of conservative care. Based on the documentation provided, the ODG would not support the requested surgical intervention as there has not been documentation of 12 months of conservative care. However, the injured worker has exhausted conservative measures and has had persistent symptoms for 10 months. It is unlikely that the injured worker will improve with additional two months of conservative treatment. Given the severity of symptoms and exhaustion of conservative measures, a deviation from the guidelines is recommended and the requested right XXXX XXXX resection versus repair for the treatment of XXXX XXXX recommended for certification and all are 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
- ☐ 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)

☐ 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.