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Patient Clinical History (Summary)

X who was injured on X. The mechanism of injury was not documented in the medical reports submitted with the request. The diagnosis was X of other specified parts of the X.

Per the note dated X by X, MD, X presented with constant X pain in the X with a pain level of X. X stated that the overall symptoms had decreased, but the X remained the same. X reported a pain level of X via X. The X had decreased with no X. The X had increased, but the X persisted. On examination, X was mildly X. The examination of the X documented postoperative surgical X that were healing well. The range of motion in X remained the same. The extension was X. The X was reported to be the same. The X was increased. There was no X. The X and the X were X. The X test, and X test were negative. The X was negative. There was no X. The physician's note documented that the reason for continuing X was due to the X, and X was gaining improvement with X(X). Treatment plan included continuation of restrictions and return to the clinic (RTC) in X weeks. On X, X reported, "I believe X have caused pain to my X." X reported a pain level of X. X had limited force to the X. X examination findings were unchanged from

previous. X was continued off work through X. Dr. X opined that considering X nature of work that required X to be on X, X needed therapy.

According to the X Daily Note dated X, X reported to X with a pain level of X in the X. The assessment documented that X was able to complete X out of X long-term goals and partially completed the last goal. X experienced pain on the X with all goal-oriented exercises. X continued to present with decreased X X and continued to X easily during the exercise. X could continue to benefit from X services that were focused on managing X pain, promoting, and promoting activity X to return to normal work activities.

An MRI of the X dated X identified X, and X.

Treatment to date consisted of surgery (X on X), X sessions of X (with improvement), and activity restrictions.

Per a utilization review and peer review dated X, the request for additional X visits, was non-certified. Rationale: “The patient has already had excessive, X sessions of similar therapy with some documented sustained functional improvement. Without new hard clinical indications for the need for an additional X, medical necessity cannot be established. Therefore, the request for additional X visits is not medically necessary. The patient is suitable for X.”

Per a utilization review dated X, and a peer review dated X, the request for additional X visits was non-certified. Rationale: “There was a previous adverse determination dated X wherein the request for X visits was non-certified. Per this appeal review, the patient is with the date of injury of X. It involved this patient's X. The patient was authorized and completed at least X sessions of structured X. The patient has been treating with Dr. X, DO, and was last seen on X. During the visit, the patient was endorsing unresolved residual symptoms. On the physical examination,

the patient's X. The X with respect to X had remained the same but X was normal. Overall X to X remained the same. The patient's X had improved overall. No other X and / or X were documented. This patient's response to supervised sessions of X had reached a steady-state and plateaued. Going forward, the X remains on this patient to continue with the home exercise program to better condition and maintain the X of the X. Any request for additional sessions of formal X exceeds the recommended guidelines, is not medically reasonable. Therefore, the requested additional X is not medically necessary. For this reason, the previous determination is upheld and remains non-certified."

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

Based on the clinical information provided, the request for X – Self-care management training X–X techniques, each X minutes X– Re-learning X–X activities that involve working directly with the provider X –X exercises and treatment for X and X recovery X is not recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination. The patient is status X on X followed by X sessions of X. Current evidence based guidelines support up to X sessions of X for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The patient has completed sufficient X and should be capable of continuing to improve X with an independent, self-directed home exercise program. Given the documentation available, the requested service(s) is considered not 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.