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Patient Clinical History (Summary)

X with date of injury X. The diagnoses were X. The mechanism of injury was not available.

X was seen by X, DC on X for continued X pain. The pain was described as X. X reported pain as severe. X had this pain for more than X year. X was status X. X stated the pain interfered with X. The pain was X with X. The pain was better with X. The associated symptoms were X. X stated X had been X with a X. X would benefit from a X evaluation and X program. On X examination, there was X. X had X. X was noted in the surrounding X. There was pain on pressure over the X. X also had pain on pressure over the X, over the X. X was decreased at X degrees with pain. X was decreased at X degrees short of X with pain. The X diminished. The X diminished. X examination showed X was diminished. X test was positive. Pain or excessive X occurred. X test was positive. X test was positive. X testing was abnormal at X. X testing was abnormal at X.

Treatment to date included X.

Per a utilization review dated X by X, DC, the requested service of X evaluation for X–X, as outpatient between X and X was non-certified as it

was not medically necessary. Rationale: “The claimant is a X with a date of injury of X. X is status post a X. The documentation provided includes an evaluation by Dr. X on X. Dr X notes that the claimant is continuing to complaint of a X pain status X. He notes that the examination indicates the claimant has X noted in the surrounding X and has positive X. X notations indicate negative problems with X and negative issues with X that is the extent of the X assessment by Dr. X. There are also indications of a decreased X and positive X test Dr. X is suggesting a X which would require a X to qualify for this type of X. There however is no indication in the history of any X that would suggest the claimant would require a X l evaluation. His Official Disability Guidelines lists several requirements for X. The number X criteria indicate that for a X evaluation, it should be based on the X screening, further evaluation by a X professional may be indicated. The results of such evaluation may suggest that the treatment options other than a X may be required. However, there is no indication in any of the records particularly in any of the current records that would indicate the claimant has any X at all. Therefore, it is not clear why a X evaluation would be required. A simple analogy may be helpful If a claimant was being referred to an X for a X evaluation of a X it would be incumbent upon the referring doctor to indicate what the X problem was and why X would be considered. In this case, there is no indication of such X issue that would need further consultation with X specialist. X Evaluation for X, X was not medically necessary.”

Per a letter dated X, X, PsyD requested a reconsideration for the denied service X. Per Dr. X , “Since this is a request for a X Evaluation and NOT for the program itself, in this scenario, Dr. X DC, as a X, is NOT a X provider and therefore NOT a peer of the requesting provider. Additionally, Dr. X stated that in his opinion that there is "no indication in the history of any X that would suggest the claimant would require a X evaluation". This demonstrates Dr. X lack of knowledge in the X field as a pain condition is clearly stated in the referring doctor X, DC on X. "Patient pain continues struggle with pain”. Per X pain is a X condition. X, X is being considered for entry into a X. Criteria for admission includes a X to assess if X meets

the X symptom requirements for X versus X. The patient will be scheduled for completion of a X examination once this request is approved."

Per a letter dated X, X, PsyD requested reconsideration for X evaluation for X. The service was non-certified. Rationale: "This case involves a now X with a history of an occupational claim from X. The mechanism of injury was not detailed in the information provided for review. The current diagnosis was documented as other X, current injury, X. The claimant had no significant past medical history identified within the clinical documentation. Surgical history included X. The claimant was being treated for X related issues following X on X. X was seen most recently on X claimed that X continued to struggle with pain. Per notes indicated X had been improving somewhat although X had sustained a burn from X when X moved it behind the X. X claimed that X related symptoms are severe, staying the same, and improving also the same context. Prescription medications modified X symptoms with claims that X had associated symptoms of X. The claimant was negative for X under X overview. On examination, the claimant had positive X . X was noted in the surrounding X with pain on pressure of the X. X had pain on pressure over the X and over the X was decreased to X degrees associated with pain with X decreased to X degrees short of X and associated with pain. X and diminished as were the X. X examination noted X diminished. The findings included positive X. The physician was recommending a X evaluation for a X with indications that the claimant was not a X candidate at that time. The prior determination dated X denied the request for X evaluation for X stating that there was no indication of any X issues that would require a X evaluation and no indication that X issues would need further consultation with a X. This request is a reconsideration for X. The Official Disability Guidelines indicate that X are intended for treatment of claimants who necessitate a X to treatment. However, the clinical documentation provided for review did not endorse that the claimant had exhausted X treatment, nor were there significant findings of X factors that would support the need for a X. The physician did not elaborate on why the claimant needed a X to treatment given that X was only noted to have

X related issues. Given that the physician did not address the prior determination issues, the current request cannot be authorized at this time. As such, the request for Reconsideration Request for X Evaluation for X, X remains not medically necessary. “

Per a letter dated X, X, MD requested reconsideration for X evaluation for X. The service was non-certified. Rationale: “Based on the clinical information provided, the Reconsideration Request for X Evaluation for X is not recommended as medically necessary. The initial request was non--certified noting that the patient has been recommended for a X which would require a X to qualify for this type of X program. There however is no indication in the history of any X issues that would suggest the claimant would require a X evaluation. The Official Disability Guidelines lists a number of requirements for X. The number X criteria indicate that for a X evaluation, it should be based on the X screening, further evaluation by a X may be indicated. The results of such evaluation may suggest that the treatment options other than a X may be required. However, there is no Indication in any of the records particularly in any of the current records that would indicate the claimant has any X issues at all. Therefore, it is not clear why a X evaluation would be required. A simple analogy may be helpful. If a claimant was being referred to an X for a X evaluation of a X it would be incumbent upon the referring doctor to indicate what the X problem was and why X would be considered. In this case, there is no indication of such X issue that would need further consultation with a X. Appeal letter indicates that the request is for a X evaluation and not for the program itself. However, it is noted that the "patient pain continues struggle with pain." There is insufficient Information to support a change in determination and the previous non-certification is upheld. The patient has been recommended for X evaluation prior to a X. However, the Official Disability Guidelines note that in order to participate in a X "The worker must be no more than X years past the date of injury." This patient is over X years past X date of injury. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.”

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

Given the current clinical data, the request for X diagnostic interview X and X – X diagnostic evaluation is not medically necessary, and the previous denials are upheld. There is insufficient Information to support a change in determination and the previous non-certification is upheld. The patient has been recommended for X evaluation prior to a X . However, the Official Disability Guidelines note that in order to participate in a X a claimant should be no more than X years past the date of injury. This patient is over X years past X date of injury. Therefore, medical necessity is not established in accordance with current evidence based guidelines." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The submitted clinical records indicate that X diagnostic interview has been recommended for this patient to determine if the patient is an appropriate candidate for a X. The Official Disability Guidelines provide a post-injury cap for X and state very clearly that the worker must be no more than X years past the date of injury. Workers that have not returned to work by X years post-injury generally do not improve from intensive X. The submitted clinical records indicate that this patient's date of injury is over X years old. Recommend non-certification of the request. 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
- ☐ 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.