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Patient Clinical History (Summary)

X who was injured on X. X stated X had significant physical activities to perform. X was X. The diagnosis was X.

On X, X was seen by X, MD for X evaluation of a X injury that occurred in X. After the injury, X went on to develop some X associated with X. An MRI confirmed that there was some degree of X. A X program had provided no relief. X had been referred for X. Examination of the X showed a little bit of X, but it looked like this would be an X. There was X. X seemed to have good X. X was a bit painful. An outside MRI of the X indicated a somewhat X as well, indicating possible X. Surgical intervention was planned and X was to continue X in the meantime.

An MRI of the X dated X demonstrated origin-X. X was to the level of the X; however, the X seen within the field of view of this examination demonstrated X. Moderate X was noted. There was X. An addendum to the report documented X seen on the X examination. Within the X there was X; however, this was not X signal as would be seen with a X and thought to X. An MRI X arthrogram would allow further assessment if clinical suspicion for X persisted.

Treatment to date included X treatment options including X.

Per a utilization review adverse determination letter dated X, the request for X, was denied with the following rationale: “Regarding the request for X, the services are not supported. Although the patient had evidence of X noted on MRI with associated symptoms during X examination, there was insufficient information to support X at this time. The physician had submitted a request for X. While it was noted that the patient had completed X sessions of X and X sessions of X and had X, given that the physician did not elaborate on what preoperative laboratory studies were being indicated, this portion of the request was left open-ended. A modification of services cannot be authorized without peer-to-peer discussion. Therefore, while a X may be warranted following an X procedure to the X, at this time, the medical necessity of the requested services was not established. As such, the request for X is non-certified. Because an adverse determination for X has been rendered, an adverse determination for any associated X is also rendered.”

Per an office visit dated X, Dr. X documented that X was denied by the insurance company as not medically necessary or appropriate. X had documented X injury with symptoms of pain. The reviewer stated that this was a X, but Dr. X noted that X cause pain and were treated with X in many instances. The reason X was done on these X was that it really worked. X had demonstrated symptoms of X. This was also a condition that caused pain in the X and was frequently treated X. They now had a picture of X and X and X that demonstrated X. X had been through X and had failed to Improve. The adjuster stated that there was insufficient information system for X intervention. Dr. X wanted to know if there was something that X was missing. This seemed to be blatant denial with no concern for X wellbeing and care. Dr. X planned to continue X treatment. Examination was unchanged from the X visit.

Per a utilization review adverse determination letter dated X, the request for X was denied as not medically necessary or appropriate. Rationale: “The ODG recommends surgery for X after the failure of three months of

conservative treatment. The ODG recommends surgery for X when the referenced criteria are met. The ODG does not address X. The medical literature supports X that failed conservative treatment. The ODG recommends X instability after failing X. The provided documentation reveals evidence of X pain and functional impairment approximately X year out from injury despite treatment activity modification, X. An MRI has revealed a X. The MRI indicates there is no definitive X and does not reveal any evidence of X. There are physical examination findings of some degree of X with findings consistent with incomplete X. When noting there is evidence of a X with persistent symptoms despite greater than X months of X treatment, the request for X is supported. As the MRI does not reveal any definitive X are not supported. There is no evidence of recurrent instability, persistent X. Based on the provided documentation, the request for X is medically necessary, but X are not medically necessary. A recommendation is for partial certification. However, as I was unable to reach the treating physician to discuss treatment modification, the request for X remains not certified at this time."

Per the office visit dated X, by Dr. X, X continued to have pain and dysfunction in X. After a period of X treatment, Dr. X had recommended surgical evaluation of the X. This had been declined by a review from X, MD who stated that X required X months of X treatment prior to X per ODG guidelines. Dr. X noted that X actually had X weeks of X and X weeks of X. X was also placed on at least a X of X. X was persistent to have pain and dysfunction in X, making it difficult for X to X. Also, Dr. X indicated that X tried to have a peer-to-peer with Dr. X on X days of X and X. In this, X stated that X left a voicemail message. Dr. X disagreed with this comment, as they were unable to have voicemails X messaging." X did not get any call for notification of Dr. X trying to get a hold of X, and felt that a stronger effort should have been performed nearly with someone as with an injury like X and try to get back to work. Dr. X would gladly have spoken with Dr. X if this call had been made. The only time that this would not probably be possible was on Tuesdays and Thursdays when Dr. X was in X. Certainly, a stronger message possibly talking to their office

manager would be more appropriate. In any case, Dr. X felt X had not been given appropriate treatment because of that. Dr. X strongly recommended an examination of the patient under X and X and would send X for another second opinion. Dr. X felt that X treatment for X had been exhausted and appropriate X was necessary. X could not return to work with restrictions as outlined on X form.

Per an XX Appeal Request Denial letter dated X, the request for X was denied by X, MD. Rationale: "This is an appeal, which the previous review was completed on X , which the request for repair of X, was denied due to no evidence of X based on provided documentation, the request for X is medically necessary, but X are not medically necessary. An additional progress note was submitted for the date of service of X, which the treating physician reported that the patient had X weeks of X and X weeks of X and at least X month of X. However, there was no evidence of X, to support the request for X. Regarding the request for X, the requested X procedure is recommended. Furthermore, the X are not medically necessary, and medical necessity was not established. Therefore, the recommendation for (X); (X); (X) X; (X) X is non-certified. Because an adverse determination for X has been rendered, an adverse determination for any X clearance is also rendered."

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

The claimant has been followed for a history of X pain which was treated with both X without improvement. The claimant had used X in the past. Despite treatment, the claimant continued to have difficulty with X function. The claimant's previous MRI study for the X is now more than X. The physical exam noted continuing tenderness to palpation over the X; however, there was no X. As the imaging studies are X and there are no current X, it is unclear how X at this point would result in any significant improvement in functioning. The potential benefits from X vs. X is unclear. Therefore, it is this reviewer's opinion that medical necessity is not established.

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.