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Patient Clinical History (Summary)

X with a date of injury X. X was X. X was X.

On X, X was evaluated by X, MD for the follow-up for X. X had been off work after X. On X, it was documented that X had X, which had been denied. X examination showed X. There was a X. On X, Dr. X opined that X did X. There were very limited options available. Dr. X suggested, due to X.

Per an appeal letter dated X, X, PhD stated that the X Evaluation also stated that X was X. X was a candidate for X. X scores did not need to be X. X scores were reported on the X Evaluation showed X. X injury was over X months old and X was considered to X.

On X, X had a X Evaluation by Dr. X. During the evaluation, X score was X which was within X. X score was X, which was X. X Assessment for Patients in X score was X indicating X. X revealed work scale of X and X scale which was X which were X. The pain resulting from X injury has had X. X reported X related to the pain and pain behavior, in addition to X. Pain had reported X. X would benefit from a course of X. That would improve X ability to cope with X. Per Dr. X, X should be treated daily in a X. The program was staffed with X in treating X. The program consisted of, but was not limited to daily X as well as X. Those intensive services would address X. X of a X was recommended. Dr. X opined that without this type of X as the X. It was crucial that X receive other necessary components, which were not provided in X.

On X, X had a X Evaluation by X, PT. The purpose of the evaluation was to determine X. During the evaluation, X was unable to achieve X. The limited factors noted during those objective functional tests included X. X was able to X and it should be noted that X job was as a X. During objective functional testing, X demonstrated consistent effort throughout X of the test, which would suggest that X put X the evaluation. Throughout objective functional testing, X reported X.

An MRI of the X revealed X. At X, there was a X. At X, there was a X. Multilevel X was noted. X was X.

Treatment to date consisted of medications X.

Per a utilization review determination letter dated X by X, MD, the request for X was non-certified. It was determined that according to functional capacity evaluation report on X, there was a documentation of X functioning at a X. According to a X evaluation report for a X, there was a documentation of the injured worker having X. There was also documentation of the recommendations to do a X. However, with X already functioning at X and therefore, the request was non-certified.

A utilization review determination letter dated X, X, MD indicated that the reconsideration request for X was denied. It was noted that there was X. In addition, the X evaluation indicated that X was able to X. Based on the available information, the medical necessity for the treatment program had not been established. Therefore, Dr. X had denied the request.

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

The patient's injury, diagnosis and course of therapy have been thorough and well-documented. This included X, as well as X. The patient has been referred to a X, since the patient still has X. Two prior utilization reviews denied the request for the X. Central to the discussion in this patient is the X. The X states that the patient can function at the X.

However, the report also states that the patient is X. This latter finding suggests that the patient cannot return to work, since these tasks appear integral to X job performance. The X Assessment identified some key components (X) that if corrected, would facilitate the patient's recovery. Given the documentation available, the requested service(s) is considered 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.