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Patient Clinical History (Summary)

X with a date of injury of X. X was X. X. The diagnoses were sprain of X.

X presented to X, MD on X for X. X sustained injuries to X on X. As a result of the X, X had an unusual X. X had X. X was X. X had difficulty X. X visited on the day for entrance into a X. X had X. On examination, X had a X. When X. X were somewhat X. Dr. X opined X was a good candidate for the X.

A X testing / assessment report was completed by X, PA on X. X scored X on the X indicating X. X score on the X was X, reflecting severe X. X responses on the X showed significant X. It was recommended that X participate in the X.

X was seen by X, DC on X for a X evaluation. X complained of X. On examination, X testing revealed X. Work category revealed that X could not completely perform in the X category on an occasional basis. Therefore, X would be listed in the X category and should be restricted to no more than X pounds of X. X ongoing X was X. Dr. X opined X would benefit from X.

An X study performed on X showed X based on absence of responses.

Treatment to date included medications X on X but was still unable to return to X, X sessions and X sessions.

Per a Notification of Adverse Determination dated X by X, MD, the requested service X was non-certified. Rationale: “The patient had completed X on X but was still unable to return to X. Per plan, X was required an X in order to X. A request for X was made. However, a X evaluation of X needed to determine the X that was completed could not be established since the actual records were not submitted for review. Also, clarification is also needed as to the actual number of hours for X the patient already had to date as the actual reports were not attached for review. In addition, there was insufficient documentation that previous methods of X have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. Clarification is needed regarding the request and how it might change the treatment recommendations as well as the patient's clinical outcomes. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request was non-certified.”

Per a Notification of Reconsideration Adverse Determination dated X by X, MD, the requested service of X was non-certified. Rationale: “Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Given that there has been a X since the completion of prior sessions, it is unlikely that X at this time would make a significant X.”

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 is not recommended as 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 submitted clinical records indicate that this patient previously completed a X. The Official Disability Guidelines note that at the conclusion and subsequently, neither re-enrollment in X is medically warranted for the same condition or injury (with possible exception for a medically necessary X. Despite prior X, the patient was unable to reach X required X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

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
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- 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.