

Becket Systems
An Independent Review Organization
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Patient Clinical History (Summary)

X who was injured on X. X reported that while working with X, X was involved in an X. There was also a X. X ongoing diagnosis was X.

On X, X was evaluated by X, MD in follow-up for X. X stated X was X from X to X. X was involved in an X. X's residual injuries included X. X was status X. In the recent past, X was hospitalized due to X. X stated X started two weeks prior and had X. A CT scan of X. X was completing X. X was X. X had X. Examination showed X.X.X.

Per the X evaluation dated X, X had received initial X. X suffered an on-the-job injury (OJI) on X while working with X, sustaining X. On X evaluation, X. X reported that X required more assistance when X. X also required X. On assessment, X was X. X presented with X. Sensation at the X was impaired.

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 the request for X did not meet guidelines, as although the records submitted indicated X had benefited with X. As such, the request for X was non-certified.

A reconsideration review letter dated X by X, MD indicated that the reconsideration request for X was denied. Rationale: "This request for X is not supported. This claimant has had X. It is unclear what benefit previous X has provided for this claimant over that period of time. There are also no X examination findings of the X. Without significant benefit from previous

X, any benefit from X is unlikely. Accordingly, this request is not medically necessary.”

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

The request for X: 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 X. It is unclear if the patient continues to make significant and sustained improvement with 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
- 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.