US Decisions Inc.
An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:
X

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified X

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

X

Patient Clinical History (Summary)

X who was injured on X. X worked as a X. X was X. X sustained a X. The diagnosis was X.

X, MD evaluated X on X for X. It had been X. The course had been X. The X. It was characterized as X. The X pain was aggravated by X. Associated features included X. It was preceded by X. Examination showed X. On X, X presented to Dr. X for a follow-up of X. X reported X had X. Associated symptoms included X. Examination revealed X.

An MRI of the X dated X revealed a X. There were X. There was X. There were X. There was X. There was a X. There was moderate X. An MRI arthrogram of the X dated X revealed X. A few X. There was X. The X. There was X. There was X. There were X. X were noted. There was X. Smaller areas of X were noted. There was a X. There was X.

The treatment to date consisted of medications X.

Per a utilization review decision letter dated X, X, MD noncertified the request for X. 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. Per evidence-based guidelines, X. In this case, the patient complained of X. X was status X. X had X. X had evidence of a X. However, the guidelines specifically note that X is still not currently supported. The indication for X is still unclear as the patient underwent this at the X. In addition, the patient has a X. X delays healing of X. Clarification is needed regarding the request and how it might affect the patient’s clinical outcomes. As the X was not recommended, the X is not supported.”

Per a reconsideration adverse determination dated X, the request for X was denied by X, MD. 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. The patient is status X. The MRI arthrogram of the X dated X showed essentially X. There was X. X present. Prior treatments included X. Evidence based guidelines requires X. It is unclear why an X is being repeated. There was X documented on the MRI. There was X provided in the treatment plan. The request for X is not supported by evidence-based guidelines. Given the provided information, this reviewer would not recommend certification for this request as it is written.”

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

The ODG supports a X. The ODG states that X. The ODG supports a X. The ODG supports X. The ODG recommends X. ODG supports X. The ODG would support the X. ODG would support a X°. The review documentation provided suggests that the injured worker has a X. A prior X was performed on X which included a X. A more recent MRI from X reveals an X. The injured worker reports X. On physical examination,

they have X. When considering the presence of a X. Utilization of a X. While the prior surgery did include a X. A revision X. Additionally, there are X. While the X is restricted, as there is evidence of X. Additionally, there is X. The documentation suggests that there may be X. As such, proceeding with a X. The imaging findings do not clearly confirm the presence of a X. Based on the ODG recommendations and available information, a X are medically necessary; however, the X are 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.