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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 with date of injury x. X suffered the injury X. The X. X was diagnosed with X.

An MRI of the X dated X showed X. There was X. The X. There was a X. There was an X. There was also a X.

On X, X underwent X by X, PA-C / X, MD. The diagnoses included X.

X underwent X from X through X. The treatment modalities included X.

On X, X presented to X, PT for a X initial evaluation. On examination, X. X was X. X was X. X was with X. There was X. X was noted to be X was noted. There was X. There was X. There was also X. On X, X noted increased X.

On X, X was re-evaluated by Dr. X for X complaints. X was X. On examination, X had a X. The assessment was X.

Treatment to date included X.

Per a letter of adverse determination dated X by X, MD the request for X was non-certified. The rationale for the denial was as follows: “In this case, the injury is X. The claimant is X. This claimant has been X. X note dated X states the claimant has X. There are X notes available for my review, I will need updated X notes with detailed, X. Given the lack of sufficient clinical information, this request is not medically necessary.”

Per a letter of Adverse Determination after Reconsideration dated X by X, MD, the request for X to the X that was non-authorized on X could not be authorized. The request for X, was non-certified. The rationale for the adverse determination noted that X was status X. Per PT note dated X, X had noted X. The requested X. The medical necessity was not deemed to have been established and therefore on review of the medical records, the proposed treatment of X was considered not appropriate and not medically necessary for the clinical diagnosis and findings.

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

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. Per a letter of adverse determination dated X by X, MD the request for X was non-certified. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient underwent X. Current evidence-based guidelines support up to X. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are X documented. 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.