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IRO REVIEWER REPORT

Date: 1/22/2018 4:15:16 PM CST

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 referral to pain management specialist

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Pain Medicine

REVIEW OUTCOME:

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

☒ Overturned	Disagree
☐ Partially Overtuned	Agree in part/Disagree in part
☐ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]: This case involves a now XX-year-old XX with a history of an occupational claim from XXXX. The mechanism of injury was XXXX. The current diagnoses are documented as lumbar spine hernias nucleus pulposus, status post lumbar spine fusion, failed back syndrome, chronic pain syndrome, and myalgia. According to the CT scan of the lumbar spine dated XXXX, it was noted that there was marked central spinal canal and bilateral foraminal stenosis at L3-L4. There was a broad-based posterior disc protrusion measuring 5 mm with thickening of the ligamenta flavum as well as hypertrophy of the facet joints. There was moderate to marked central spinal canal and bilateral foraminal stenosis at L2-L3. There was central spinal canal and left foraminal stenosis at L1-L2 secondary to posterior and leftward disc protrusion measuring 3.3 mm. It was reported that the patient had long history of low back pain. Prior treatment included medications, surgical interventions, and physical therapy. In the clinical note dated XXXX, the patient complained of low back pain that radiated into the bilateral thighs down to the feet. The patient stated that his pain was gradually getting worse and rated his pain to be a 7/10 severity. The patient stated that his pain interferes with work, sleep, recreational activities, and activities of daily living. Activity was noted to have exacerbated his pain. Upon physical examination, there was a loss of joint motion with motion palpation. Range of motion was limited and associated with pain. Straight leg raise test was positive. There was poor trunk, back extensor muscle strength. The treatment plan included for the patient to undergo a referral to a pain management specialist.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

According to Official Disability Guidelines, office visits and referrals are recommended. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The patient had elevated pain that was interfering with work and activities of daily living. The patient stated that the patient was getting worse. The patient had a decrease in muscle strength and range of motion. Although the patient has had a long history of medical intervention for his low back complaints, it is reasonable and recommended for the patient to receive a referral at this time. As stated above, the patient has functional deficits in basically all activities. The patient has an elevated pain score that is exacerbated by activity and is progressively getting worse. Medical necessity has been established.
Therefore, the request for 1 referral to pain management specialist is medically necessary and the prior determination is overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR 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 & TREATMENT GUIDELINES
☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
☐ TEXAS TACADA GUIDELINES
☐ TMF SCREENING CRITERIA MANUAL
Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Low Back - Lumbar & Thoracic (Acute & Chronic), Office visits