CASEREVIEW

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April 2, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX (XX) XX XX for Purchase between XX and XX.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician has over 20 years of experience in Physical Medicine and Rehabilitation.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XX year old XX who was injured on XX after XX XX and XX XX XX at work. XX received XX therapy sessions, ice, moist heat, and anti-inflammatories.

On XX, X-ray XX XX Impression: XX XX XX. Consider XX-XX disease, XX XX, XX XX or XX.

On XX, the claimant presented to XX with XX XX pain. XX described the pain as worsening since XX. It radiates into XX XX XX XX. It is a deep ache, stabbing-type pain that XX would rate from a 4 to 9 on a scale of 10. On physical examination in had 5.5 in all XX. Sensation in all XX were intact. Negative straight-XX raise. Reflexes were equal and intact at XX and XX. Decreased flexion and extension at the XX, had moderate to extreme range of motion secondary to pain as well as some hypertonicity in XX XX muscles groups. Assessment: 1. XX strain. 2. XX. 3. XX radiculopathy. 4. XX degeneration. Plan: XX should continue with XX therapy. We will obtain an MRI and some flexion-extension x-ray views. XX was prescribed XX as well as pain cream for pain control.

On XX, XX MRI Impression: 1. Acute XX nodes in XX, XX, XX, and XX. 2. XX XX XX as above, severe at XX with moderate at XX/XX and XX/XX from combination of disc disease, facet XX and XX shortened XX. 3. Mild diffuse XX XX of uncertain significance. Consider of XX XX disease, hereditary XX or XX XX. Atypical congenital variant XX

bodies may have this appearance.

On XX, the claimant presented to XX for XX eval. Assessment: Patient reports originally having XX pain XX years prior, diagnosed with XX DJD of the XX. Patient reports progressive XX XX/XX pain after XX XX XX XX XX XX at work on XX. Patient reports that XX has an appointment with a neurologist. Due to patient's reported and present signs and symptoms, recommend further diagnostic testing before proceeding with XX therapy.

On XX, the claimant presented to XX with continued XX XX pain. XX did not feel XX was capable of participating in XX therapy due to XX severe pain. XX was referred to a pain management specialist. XX was prescribed a XX XX x 1 to decrease inflammation and provide some pain relief along with XX XX mg XX. XX also received refill of XX XX No. XX and XX.

On XX, the claimant presented to XX for pain management. XX reported a pain level of 4 when stationed that increased to a 10 upon movement. XX symptoms improve with crouching down, medications and position change, leaning more towards the XX XX. The symptoms are exacerbated by XX a XX, activity, XX XX and standing or walking. The pain is worse in the mornings, afternoon and evenings, throughout the night. XX reported XX XX-XX XX multiple times XX the XX. XX reported severe weakness to the XX XX XX. When moving from a seated to standing position XX is unable to place any weight on the XX XX due to the weakness. Should XX try and bear weight on the XX it does buckle under XX. On examination flexion was painful. Shopping cart sign positive. Straight XX raise positive on the XX at 50 degrees and positive on the XX at 65 degrees. There was weakness in the LLE. XX jerk and XX jerk were diminished XX. Recommendation: Proceed with LESI XX-XX. Prescribe XX XX, XX XX mg, and XX XX mg.

On XX, the claimant presented for a XX epidural steroid injection.

On XX, the claimant presented to XX with continued XX XX pain. On physical examination there was positive straight XX raise XX at about 5 degrees of flexion with onset of pain and about 5 degrees of extension with full onset of pain. Significant hypertonicity in XX XX muscles. XX struggled with XX rise. XX struggled with XX stance and walked with an antalgic type gait. Decreased reflex at XX through XX. Plan: Before any sort of surgery, which this is definitely a surgical case at this point, I would like to repeat the MRI and then make further treatment decisions once the repeat MRI.

On XX, the claimant presented to XX reporting no relief from the LESI. XX also had filled XX XX #XX prescription with was in XX of the XX XX. XX was XX off XX to XX due to XX XX XX.

On XX, the claimant presented to XX with XX XX pain radiating down XX and XX XX. The pain was rated a 6. On examination there was muscle spasm present. Positive XX test. XX straight XX raise was painful at 30 degrees. XX straight XX raise was painful at 30 degrees. Sensory was intact to light touch. Plan: 1. Interventional Pain management: the patient reports increased pain and a sense of instability in the XX region when ambulating and standing for prolonged periods of time. It is my hope that the patient's XX stability and pain will be reduced by restricting mobility of the XX with an appropriately fitted XX XX. Prescribed a XX (XX XX w/o supports XX XX) XX with posterior and lateral supports. 2. Medical Pain Management: Prescription provided were XX XX mg and refill of XX XX/XX.

On XX, XX performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request in non-certified. Per evidence-based guidelines, XX supports are recommended as an option for compression fractures and specific treatment of XX, documented instability, and for the treatment of nonspecific XX (very low-quality evidence, but maybe a conservative option). In this case, there was insufficient documentation of objective findings in the recent medical report that would suggest significant pathological deficits and functional limitation which indicate the need for this request. There was no quantifiable measurement for the range of motion of the XX XX. Guidelines indicated that a systematic review on preventing episodes of XX problems found strong, consistent evidence that exercise interventions are effective, and other interventions not effective, including XX XX, XX

inserts, XX supports, ergonomic/XX education, and reduced lifting programs. Telephone contact was established with a designee for the office of XX. It is confirmed there is no recent fracture or XX instability that supports use of the LSO XX at this stage of chronic pain management.

On XX, XX performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request in non-certified. Per evidence-based guidelines, XX supports are recommended as an option for compression fractures and specific treatment of XX, documented instability, and for the treatment of nonspecific LBP (very low-quality evidence, but maybe a conservative option). In this case, The provider asked for reconsideration of the denial of the XX XX since the patient's condition had been deteriorating; however, there was still insufficient documentation of objective findings in the recent medical report that would suggest significant pathological deficits and functional limitation which indicate the need for this request. There was still no quantifiable measurement for the range of motion of the XX XX. Guidelines indicated that a systematic review on preventing episodes of XX problems found strong, consistent evidence that exercise interventions are effective, and other interventions not effective, including XX XX, XX XX, XX supports, ergonomic/XX education, and reduced lifting programs. Moreover, there was still no documentation of any recent fracture or XX instability that supports use of the XX XX at this stage of chronic pain management.

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

Determination: Denial of XX Orthosis is UPHELD/AGREED UPON since there is no documentation of compression fracture, XX, or objective instability of the XX XX. There is also no documentation of participation in a XX therapy program or instruction in/compliance with a home exercise program in conjunction with use of XX so as to ward off further deconditioning in this now chronic case XX months post injury. Therefore the request for XX XX (XX) XX XX for Purchase between XX and XX is not medically necessary at this time.

PER ODG:

XX supports

XX

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**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW XX PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**