Applied Assessments LLC

Notice of Independent Review Decision

Case Number: Date of Notice: 7/15/2019 12:15:43 PM CST

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Records –X
• Diagnostic Data Reports X
• Notice of Adverse Determination –X
• Review Summary –X
• Notice of Reconsideration Adverse Determination –X

PATIENT CLINICAL HISTORY [SUMMARY]: X with a date of injury X. X XX X XX while XX. X was diagnosed with an X. On X, X was evaluated by X, MD. X was referred by Dr. X for an evaluation of the X pain. X was diagnosed with an X and recovered from that but had continued outside of the X pain. X could pinpoint with X. The pain was described as a X and was rated as X. The pain worsened X continued to wear X and had pain with increased activity. On examination, X showed X. X was able to X. There was X over the X and X process. X was -X degrees with the X extended and X flexed. X was X degrees, X 3, and X degrees. There was first X present. An MRI of the X dated X revealed X; marrow X along the X of the X. The X was likely reactive in nature, related to abnormal X. X, located just X was noted at the X. A CT scan of the X dated X showed X along the X, which appeared extra-X, without evidence of X suggesting X. X with slight X of the X was noted. That was the site of X as seen on the recent MRI examination. There was healed X and X. Treatment to date included X. Per a utilization review determination letter dated X by X, MD, the request for X was denied. It was determined that the X were not recommended for X. X had complained of X pain described as X that was worse with X on exam. The guidelines also stated that when approval occurred for individual patients beyond those guidelines, then

only a X using X doses and minimal-to-no X would be advised. Given the chronicity of X injury, clarification was needed if X had already received a one-X using X doses as X previous medical records were not submitted for review. Clear exceptional factors were not identified to support the proposed injection at the time. Based on the information provided, guidelines reviewed and lack of successful peer discussion, the request was not medically supported at the time and thus, non-certified. A letter by X, MD dated X indicated that the reconsideration request was denied / non-certified. 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. There were no actual records submitted to objectively verify this information. The current request is an appeal for X. Per evidence-based guidelines, X is not recommended. In this case, there was a previous adverse determination dated X whereby the request for X into the X was non-certified. Also, X have very poor evidence for X conditions with potential for harm, higher-quality research also results in non-recommendation for most other forms of X. Exceptional factors were not identified."

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

The ODG does not recommend X for the X but states that when approval occurs for individual patients beyond these guidelines, then only a one-X would be advised. The provided documentation reveals evidence of persistent X pain approximately X months out from injury despite treatment with medications and immobilization. An MRI from February X revealed X along the X. There is also evidence of a X. A CT scan from X revealed an X. On X, the treating provider indicates to discuss both operative and nonoperative treatments for the imaging findings related to the X with ultimate recommendation for a X. The injection was initially denied on X with the reviewer indicating clarification was needed to determine if the injured worker already received a one-X as previous medical records were not submitted for review.

However, the current review documentation includes notes dating back to X without evidence of X. When noting the persistent symptoms greater than X months out from injury despite treatment with medications and immobilization and when considering the alternative intervention to X would likely be X, proceeding with an X was advised as it would be prudent to exhaust all nonoperative measures prior to progressing to surgical intervention.

As such, recommendation is for X the two prior denials. Given the documentation available, the requested service(s) is considered medically necessary.

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

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☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

-- ODG, 2019: XX and XX