IRO Express Inc.

Notice of Independent Review Decision

Case Number: Date of Notice: 6/13/2019 6:11:55 PM CST

IRO Express Inc.

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IRO REVIEWER REPORT

Date: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

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

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

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW: Clinical Records –X
- Texas Workers' Compensation Work Status Reports –X
- Utilization Review Determination Letters –X

PATIENT CLINICAL HISTORY [SUMMARY]: X. X X is a X-year-old X with date of injury X. X. X had XX X and felt pain in the X. X was diagnosed with X. X. X underwent X including X therapy on X, and X. On X, X. X complained of X pain. X condition had remained unchanged. X complained of X. On examination, X was noticed in the X. X were noted in the X. X findings were noted in the X region. On assessment, the pain X. X. X visited X, DO on X for a follow-up of X pain. X reported using X with temporary improvements. X reported having X symptoms to X described as X. X stated that at its worse it shooted all the way down to the X. Examination of the X revealed pain with movement, which was moderate with X. Examination also revealed X with noted tonicity to the X. The X was decreased in all planes with an increased pain on X. The X test was positive on the X. The motor examination and reflexes were intact. There were X changes to the X and X compared to the X. The diagnosis included X of the X. X. X was seen by X, NP on X for a follow-up of X pain.

X reported using X with temporary improvements. X reported having X symptoms to X described as X. X stated that at its worse it shooted all the way down to the X. Examination revealed X with noted X muscles. The X was decreased in all planes with an increased pain on X. The X test was positive on the X. The motor examination and reflexes were intact. There were X changes to the X. An MRI was requested to rule out X. No diagnostic investigation reports were available in the provided medical records. Per the utilization review determination letter dated X a discussion with the physician assistant indicated that the x-ray findings had been unremarkable. The treatment to date consisted of X (caused worsening pain), nonsteroidal anti-inflammatory medications, over the counter medications (temporary improvement), and massage therapy (minimal improvement). Per a utilization review determination letter dated X, it was decided that the services or treatments described were not medically necessary or appropriate. It meant that these services or treatment were not approved. Rationale: "Regarding the requested X, the patient presents status X injury to the X. However, the submitted documentation did not clearly reflect X as evidenced by diminished X and X correlating with a particular X in order to support the request. As such, the request for X is non-certified." Per a utilization review determination letter dated X, it was determined that the request for X of the X still did not meet the medical necessity guidelines. The request had been reviewed by X, MD. The prior denial reason was reported as submitted documentation not clearly reflecting X as evidenced by X with a particular X in order to support the X. Rationale: "ODG Guidelines note that X is indicated for X pain or X candidate with persistent or progressive symptoms during or following 6 weeks of conservative management. In this case, the claimant presents with X pain with X symptoms to the XX XX XX described as numbness and tingling and shoots all the way down to the XX surface of the XX X at its worst. Examination reveals a positive X but there is no description of the symptoms provoked. X changes to the X compared to the X is noted. The provider recommends X to rule out X. However, the claimant was less than X status date of injury at the time of the visit and there is no evidence of trial and failure of conservative treatment. The claimant has only attended 2 sessions of therapy. In the absence of red flags, a full course of treatment should be trialed prior to advanced imaging. Therefore, the medical necessity of the requested X is not established. Recommend non-certification for the request of X."

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. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient's physical examination notes that X. There is no clear rationale provided to support the requested X at this time.

Therefore, medical necessity is not established in accordance with current evidence based guidelines and the decision X.

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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