AccuReview

An Independent Review Organization
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[Date notice sent to all parties]: June 10, 2019

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:

This physician is Board certified in Anesthesiologist with X 17 years of experience.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X: MRI X at X dictated by X, MD
X : Office Visit dictated by X, MD
X: UR performed by X, MD
X : Office Visit dictated by X , MD
X: Appeal at X Medical dictated by X, MD
X: UR performed by X, MD

PATIENT CLINICAL HISTORY [SUMMARY]:
X: MRI X dictated by X, MD. Impression: 1. X changes at X with X and X. No X or X neural X and mild to moderate central X. Moderate to severe X neutral X with mild X. No acute X.

X: Office Visit dictated by X, MD. CC: X pain with radiation to the X. X has had pain for about X months, that started after X. X stated X was X which caused X to XX XX and go off the XX, causing X X-X to X X and was seen at the X a few

days later. DOI X. Pain described as X. Pain is aggravated by X and X. Pain X at its worst and X at its best. Workup includes MRI X. Current medications: X for pain. X completed last week which did help, prior X pain management includes none. Other associated complaints/symptoms include X. Denies pain prior to the accident.

X : UR performed by X, MD. Reason for denial: Based on review of the available documentation and corresponding evidence based medical treatment guidelines, as well as any additional information obtained in a peer-to-peer teleconference when available, is/are the following services and/or medications medically necessary? X X under fluoroscopic guidance and X, as an outpatient for the submitted diagnosis of X of X. Based on the clinical information provided, the request for X under fluoroscopic guidance and IV sedation of X, as an outpatient for the submitted diagnosis of X of X is not recommended as medically necessary. There is no comprehensive assessment of treatment completed to date or the claimant's response thereto submitted for review. There is no documentation of extreme X provided to support the request for X. Current evidence based on guidelines note that the use of X (including other agents such as X) may be grounds to negate the results of a X and should only be given in cases of extreme X Therefore, medical necessity is not established in accordance with current evidence-based guidelines. Not medically necessary.

X : Office Visit dictated by X, MD. CC: X pain with radiation to the X than X. Upon further discussion had X therapy with Dr. X 3x per week for 4 weeks and at X Therapy for 7 sessions. Claimant stated medications help a little and X helped with increased function and mobility but continues to experience pain. Further claimant will be okay without sedation just as long as X does no see X. X: X: positive for X & X, positive X worse on extension. Assessment: X (mild), X, initial encounter. Plan: X sprain: continue with X pain treatment protocol –X management, X therapy as needed with emphasis on X restoration program. Exercise encouraged with safe, low impact, supervised exercise. Avoid X and to be strict with regard to ergonomic positioning as well as exercise techniques. Encouraged X therapy applied for 15-20 minutes. X of X: after the claimant's history and physical exam and the fact that X has tried and failed X measures including X management and X therapy therefore recommend proceeding with X under fluoroscopic guidance X if necessary. The details of the procedure including the risks, benefits, options, expectations and realistic goals were discussed. Claimant continues to have X pain with X radiation with X worse than the X , claimant has had physical therapy for several weeks as noted above and has been on medical management for about 8 weeks but continues to have significant pain and X management, physical exam findings consistent with X XX XX/X, X symptoms and physical exam therefore, recommend proceeding with X medial X under fluoroscopic guidance, although X is somewhat XX X stated that X will be able to continue/we'll try proceeding with interventional pain management without sedation. Procedure: Claimant scheduled for the X. DX: X
X: UR performed by X, MD. Reason for denial: The claimant has X pain with radiation into the X. On physical exam there is tenderness with X. Guidelines state X is recommended if no more than one X is recommended. The request exceeds these guidelines and is therefore denied.

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

Based on the records submitted and peer-reviewed guidelines. The claimant has X XX pain with radiation into the X. On physical exam, there is X. Guidelines state X is recommended if no more than one X is recommended. The request exceeds these guidelines and is not medically necessary. Therefore, after reviewing the medical records and documentation provided, the request for X Fluoroscopic guidance and IV sedation of X is upheld and denied.

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 BACK 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)**