Applied Independent Review

An Independent Review Organization

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Case Number: **XXXX** ***Date of Notice:*** 05/08/2019

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Physical Medicine And Rehabilitation
Pain Medicine

Description of the service or services in dispute:

XXXX XXXX XXXX XXXX XXXX on the XXX 1

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

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Information Provided to the IRO for Review:

Clinical Records – XX
- Notice of Adverse Determination – XX
- Appeal Letter – XX
- Diagnostic Data Reports – XX

Patient Clinical History (Summary)

XXXX. XXXX XXXX is a XX-year-old XXXX with date of injuryXXXXX. XXXX XX on a XX and landed on XXXX . XXXX reported that XXXX had pain in XX XX XX XXXX , and XXXX . XXXX was diagnosed with sprain of XX of XXXXXX .

On XX, XXXX. XXXX was seen by XX , MD for XX pain. The pain radiated into the XX extremity. XXXX was able to sit, stand, and walk for more than XX minutes. XXXX rated the pain at 5/10. The pain level at worst was 7-9/10 and at best was 2-3/10. XXXX had constant stabbing and aching pain. XXXX felt better with the injections and medications. On examination, XX and XX was poor on the XX . XX was positive on the XX.

An XXXXI of the XXXX XX dated XX demonstrated XX and XX with no mild disc XX at XX and mild XX, there were grade 1 XX of XXX, XX, 2-mm XX and no XX. Patent XX and XX were noted. At XX, there were XX slightly eccentric to the XX not contacting the XX and mild XX. Patent XX and XX were noted. An x-ray of the XXXX XX dated XX showed straightening of the normal XXXX XX – could be due to XX muscle spasm.

The treatment to date included physical therapy, medications (XX, XX, XX, XX, XX, and XX), and XX.

Per a utilization review decision letter dated XX, the request for XXXX XXXX XXXX XXXX at the XX level on the XX was denied by XX, MD. Rationale: "Regarding the request for the repeat XXXX XXXX XXXX, the patient reported XX pain that radiated to the XX extremity.
Physical examination revealed a positive XX on the XX. The patient received a clinically significant benefit from the previous XXXX XXXX XXXX. However, XXXX did not reveal nerve root compression and there was no indication of significant XX to specific XX and XX related to the requested level. As such, the request for XXXX XXXX XXXX XXXX XXXX at XXXX on the XX x1 is noncertified."

Per a utilization review decision letter dated XX, the request for XXXX XXXX XXXX XXXX at XX level on the XX was denied by XX, MD. Rationale: "According to the referenced guidelines, a repeat XXXX may be appropriate for patient if there is evidence of XX pain relief lasting at least 6-8 weeks. Additionally, there must be documentation of a decreased need for pain medications and a functional response. Within the notes, it was detailed this patient had an appropriate pain relief; however, the patient rated XX pain at a 5/10 at XX visit and a 4-6/10 at the XX visit, this would not be consistent with the appropriate sustained pain relief. The patient underwent the previous XXXX on XX; therefore, additional injections at this time would not be supported. Furthermore, the patient does not have any type of compromise to the foramina on imaging. As such, the requested XXXX XXXX XXXX XXXX XXXX at the XX on the XX is not medically necessary. The request for XXXX XXXX XXXX XXXX XXXX at XX on the XX times one is noncertified."

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 XXXX XXXX XXXX XXXX XXXX XX on the XX times one,
XX XX for diagnostic or XXXX XX and XX, XX XXXX(s), of diagnostic or XXXX substance(s) is not recommended as medically necessary, and the previous denials are XX. Per a utilization review decision letter dated XX, the request for XXXX XXXX XXXX XXXX at the XX level on the XX was denied by XX, MD. Rationale: "Regarding the request for the repeat XXXX XXXX XXXX, the patient reported XX pain that radiated to the XX extremity.
Physical examination revealed a positive XX on the XX. The patient received a clinically significant benefit from the previous XXXX XXXX XXXX. However, XXXX did not reveal nerve root compression and there was no indication of significant XX to specific XX and XX related to the requested level. As such, the request for XXXX XXXX XXXX XXXX XXXX at XXXXon the XX x1 is noncertified." Per a utilization review decision letter dated XX, the request for XXXX XXXX XXXX XXXX at XX level on the XX was denied by XX, MD. Rationale: "According to the referenced guidelines, a repeat XXXX may be appropriate for patient if there is evidence of 50-70% pain relief lasting at least 6-8 weeks. Additionally, there must be documentation of a decreased need for pain medications and a functional response. Within the notes, it was detailed this patient had an appropriate pain relief; however, the patient rated XX pain at a 5/10 at XX visit and a 4-6/10 at the XX visit, this would not be consistent with the appropriate sustained pain relief. The patient underwent the previous XXXX on XX; therefore, additional XX at this time would not be

supported. Furthermore, the patient does not have any type of compromise to the XX on imaging. As such, the requested XXXX XXXX XXXX XXXX XXXX at the XX on the XX is not medically necessary. The request for XXXX XXXX XXXX XXXX XXXX at XX on the XX times one is noncertified." There is insufficient information to support a change in determination, and the previous non-certification is XX . The patient underwent XXXX XXXX XXXX XXXX at XX on XX. Follow up note dated XX indicates that the patient's pain level is 4-6/10. Follow up note dated XX indicates pain level is 5/10. It is reported that the patient was able to decrease medications; however, pre and post-XXXX medication regimens are not documented. There are no specific objective measures of improvement documented. The Official Disability Guidelines require documentation of XX on physical examination corroborated by imaging studies and/or electrodiagnostic results. There is no significant XX pathology documented on XXXX XXXXI. Given the documentation available, medical necessity is not established in accordance with current evidence based guidelines and therefore the decision is XX.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ 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 and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)

- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)