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Notice of Independent Review Decision

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: X

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:

• X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was involved in a work-related injury on X. X stated X was X. X felt immediate pain in X neck, mid back, low back and whole right side of X body. The diagnosis was low back pain (M54.50). On X, X was evaluated by X, DO for a follow-up of lumbar back pain. Pertaining to the lumbar back pain, X reported that X continued to have aching, sharp, constant, throbbing pain localized to X lumbar spinal process, paraspinal musculature more on the right than on the left, which was worse with X range of motion, activities, heavy lifting, pushing, standing, walking, driving, and house chores. X also reported numbness and tingling sensation radiating down to X bilateral feet, more on the right. X was recommended a X previously, which Workers' Compensation did not approve. X reported that X worked at X. X wished to have work restriction saying that X should not lift more than X pounds at a time, and X should not do any walking, pushing, and pulling. X reported that X worked a sitting type of work with making phone calls. X also reported that due to X lower back pain and lower extremity numbness, tingling, and giving out sensation from X lower back, X was unable to walk long distances. X used a X. On examination, X weight was 240 pounds. X had X. Lumbar spine examination revealed range of motion in lumbar flexion was X degrees, hyperextension to X degrees, lateral bending to X degrees, and forward and backward rotation X degrees. Pain was elicited with this range of motion. There was X. Sensation on the upper thigh, mid-thigh, and medial calf, dorsum of the foot and lateral/sole of the foot was X. X felt numbness and tingling. Lumbar MRI from X showed X. Dr. X opined that it was more likely than not the injuries were caused by the work-related injury on X. The assessment was X. X was advised X. For the lower back pain and lower extremity radiculitis, X was recommended to have X previously, which had been denied by Workers' Compensation. Dr. X recommended a peer-to-peer review to discuss this matter, which they were awaiting still. At the time, X was given work restrictions as per X request, and X was also given a handicap placard as per X request. X was given a prescription refill for X On X, X was evaluated by Dr. X for follow-up of X work-

related injury. Pertaining to the lumbar back pain, X reported that X continued to have aching, sharp, constant, throbbing pain localized to X lumbar spinal process, paraspinal musculature with stiffness, spasm, and tightness. X also reported numbness and tingling sensation radiating down to X feet bilaterally, more on the left than on the right at the time. X reported pain with activities such as heavy lifting, pushing, standing, walking, driving, house chores, and also with range of motion, X was recommended to have X previously, which Workers' Compensation did not approve yet. X had some work restrictions given, and X wished to continue with the same work restrictions at the time. On lumbar examination, ROM showed lumbar flexion to X degrees, hyperextension to X degrees, lateral bending to X degrees, and forward and backward rotation to X degrees. Pain was elicited with this range of motion. On palpation, X had tenderness with triggering, tightness, and spasm noted on the lumbar midline and lumbar paraspinal musculature. Lower extremity sensation was decreased on the upper thigh and mid-thigh bilaterally as well as the dorsum of the foot bilaterally. The assessment was unchanged. For the lower back pain, X was awaiting the X and awaiting a peer-to-peer review due to the Workers' Compensation continued denial of this. X wished to be sedated for this X and inability to stay still. X would continue with X work restrictions as recommended. An MRI of lumbar spine dated X revealed X. At the X, there was early tortuous height loss and desiccation. There was a X. X was patent. X were patent bilaterally. There was early X seen. At the X, there was early X. There was a X. Early X was seen. X was patent. X were patent bilaterally. The visualized X. Treatment to date included medications X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Regarding X, ODG states that X. X must be corroborated by imaging studies and when appropriate, electrodiagnostic testing, unless documented pain, reflex loss, and myotomal weakness abnormalities support a dermatomal radiculopathy diagnosis. A request for the procedure in a patient with chronic radiculopathy requires additional documentation of recent symptom worsening associated with deterioration of neurologic state. Candidates must be unresponsive to conservative treatment (eg, exercise, physical therapy, nonsteroidal anti-inflammatory drugs, muscle relaxants, neuropathic drugs). In this case, the pain is not described specifically at X. There are limited findings on examination consistent with X. Guideline criteria has not been met, therefore, the medical necessity of this request is not established. The recommendation is to deny. "Per a reconsideration review adverse determination letter dated X by X,

MD, the appeal request for X was denied. Rationale: “The appeal request for X is not recommended as medically necessary. It is unclear what specific treatment the patient has received for the low back. There is no X noted on MRI. There is a X. Therefore, medical necessity is not established in accordance with current evidence based guidelines. “Thoroughly reviewed provided records including imaging findings and peer reviews. Patient attempted conservative treatment for over a year without success and has pain in radicular distribution based on description of pain. X pain does not necessarily correlate with the requested X. The 2 peer reviewers do not appear to take these factors in to account. Based on these factors, the patient does meet cited ODG criteria for X. Patient also warrants X is medically necessary and certified

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

Thoroughly reviewed provided records including imaging findings and peer reviews. Patient attempted X. X pain does not necessarily correlate with the requested X. The 2 peer reviewers do not appear to take these factors into account. Based on these factors, the patient does meet cited ODG criteria for X. Patient also warrants X is medically necessary and certified

Overturned

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

☐ TMF SCREENING CRITERIA MANUAL