**Independent Resolutions Inc.**
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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 injured on . When lifting a *heavy* pallet, X injured X low back. The diagnosis was chronic back pain syndrome with recurrent left-greater-than-right lumbar radiculopathy having failed surgical, rehabilitative, and medical treatment options; failure to respond to spinal cord stimulation; and generalized deconditioning and myofascial pain in a patient with history of depression, smoking, and caffeinated beverage consumption X was evaluated by X, DO on X for continued moderate-to-severe back, left buttock, and left leg pain. Over X months ago, X got excellent relief X, and X wanted to reinstitute this care. Once again, X had a positive straight leg raising sign, and moderate lumbar interspinous tenderness. X medicines had stabilized to include X. X effect had improved. X pain scores however, were escalating. However, X was dealing with it much better, knowing X could help X as it had in the past. Due to X, Dr. X recommended that this be performed in minimal sedation, which X received in the past. In the meantime, X was to avoid heavy lifting, bending, or twisting. On X, X presented to Dr. X complaining of severe back, left buttock, and left leg pain below the level of the knee. X reported that over a year ago, X got excellent relief utilizing X. X failed X, the best relief thus gained had been X for recurrent lumbar radiculopathy associated with post lumbar laminectomy pain syndrome. At the time, X described X pain as sharp, shooting in nature and rated it X, requiring ongoing X. Dr. X was trying to eliminate X. X was on X on a steady basis. At the time, X walked with an X was noted. As a result, Dr. X would recommend X to be imposed in the near future. X

was representing anxiety and fear with this procedure and did require minimal sedation in the prone position at X last visit, and they would recommend this as soon as possible. Treatment to date included medications (X). Per a utilization review adverse determination letter dated X, the request for X was denied by X, DO. Rationale: “The Official Disability Guidelines stated that X are not routinely recommended unless there is evidence of an acute pain exacerbation after a symptom-free period. This criterion is based on an emerging concept that the true natural history of lumbar radicular pain due to intervertebral disc herniation often follows that of a relapsing remitting disease, with temporary occurrences of symptoms over the years. The following criteria must all be meet - require documentation that previous X. On X, the claimant presented to the office complaining of moderate to severe back pain with left buttock and left leg pain. The assessment revealed positive straight leg raise and moderate lumbar paraspinous tenderness. However, the result of the previous X was not detailed. There is no documentation of continued rehabilitation in association with the injection request. Furthermore, the objective findings do not specifically determine what dermatomal area is affected. Thus, the request for a X, per X order is non-certified. “On X, Dr. X appealed the denial of the request for X. Due to anxiety, fear of needles, X would require X. Per a reconsideration review adverse determination letter dated X, X, MD denied the appeal request for X. Rationale: “Regarding the appeal request for X site conditionally recommended as a short-term treatment for lumbar radicular pain (defined as pain in a dermatomal distribution) with corroborative findings of radiculopathy. This treatment should be administered in conjunction with X. X is not generally recommended. When required for extreme anxiety, a patient should remain alert enough to reasonably converse. X is not a stand-alone procedure. There should be evidence of active rehabilitation in association with X. This can include a continuing X. The claimant had ongoing low back pain radiating

down the left lower extremity. There was tenderness on palpation of the lumbar spine with a decreased pinprick in the X distribution. The claimant represented anxiety and fear regarding the X. However, there was a lack of documentation of functional improvement with the prior X and there was no indication the claimant was participating in an adjunct X, As such, the appeal request for X, is non-certified. “Based on the submitted medical records, the requested X is not medically necessary. A prior X that was performed. No documentation was provided to demonstrate functional improvement following this X. In addition, there is no documentation that the patient is completing a X. X is not medically necessary and non certified

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

Based on the submitted medical records, the requested X is not medically necessary. A prior injection was performed. No documentation was provided to demonstrate functional improvement following this X. In addition, there is no documentation that the patient is X. X is not medically necessary and non certified

Upheld

**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