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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 Overtuned 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 X. X was lifting a table and heard a pop. The diagnoses were chronic pain syndrome, lumbosacral radiculopathy, lumbar post-laminectomy syndrome, and long-term current use of X. On X, X was evaluated by X, PA-C /X, MD for a follow-up visit for X. X reported work-related injury on X. Later, X had X. Also, X had "RT" a slip and fall. X had X. X was status X. X had X. X was replaced in X. At that time, X reported low back pain, radiating to the legs. The pain was aching, sharp, shooting, burning, and constant in nature. The ongoing pain level was X; worst pain level X; percentage of pain relief with medications was X. Alleviating factors included massage, heat therapy, exercise, relaxation and opioids, and aggravating factors included movement and stress. Regarding activities of daily living (ADL) improvements, overall function was improved. X presented on the day for X. X reported that X. Low back pain (LBP) had improved with ongoing pain medications that X took for "BT" with at least X pain relief and no side effects. X presented for X. They would be X with X and X was requesting X. On examination, X blood pressure was 128/74 mmHg, weight was 183 pounds and body mass index was 26.3 kg/m2. X was ambulating without assistance. Neurological examination revealed X. There was normal sensation, tone, and motor strength. On assessment, X adjustment was performed, and refilled with medications including X. X and X monitoring were recommended. Regarding chronic pain syndrome, medications would be refilled at the usual strength and dose as they continue to reduce pain and improve functional ability. X requested an increase in concentration so that X may return every three months. Therefore, the concentration was increased from X to X mg/mL. A urine drug screen was reviewed which was positive for X. Treatment to date included medications X. Per a peer review report dated X and utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: "According to an office note by Dr. X on X, there was documentation of the injured worker having listed diagnoses of chronic pain syndrome, lumbosacral radiculopathy, and lumbar post laminectomy syndrome. There was also documentation that the injured worker had a previous X. There was also documentation that the injured worker had an X. There was also documentation that the listed medications included X. Physical exam revealed X. The treatment plan included a X. However, with physical exam revealing X. There

was also no documentation detailing why the injured worker could not be managed only with X. There was also no documentation detailing what specific additional functionality has been achieved with the X. Therefore, given these circumstances and the guidelines, there is no support for the requested X is non-authorized. “On X, an appeal for reconsideration of request of X was placed by X and requested to review the clinical and letter of medical necessity. Per an undated Letter of Medical Necessity completed by X, PA-C documented that X had a chronic pain condition. As such X had a many year history on utilizing X. X consistently had reported significant decreased pain and improved functional ability and improved quality of life because of the X. At every office visit, X demonstrated that X was alert and functioning well. The decision and approval to place an X. The delivery of X. The reviewer had concern that X physical exam findings were X. It did appear that physical examination of the lumbar spine was not documented and as X. There likely would be positive findings if this had been documented appropriately. X was requesting to consider that the X. At the juncture, denial of or delay of the X. Per a peer review report dated X and a reconsideration / utilization review adverse determination letter dated X and by X, MD, the request for X was denied. Rationale: “There is limited objective findings to support efficacy from X. Hence, medical necessity of this request is not established. “Thoroughly reviewed provided records including peer reviews. Patient with chronic pain issues and has resorted to X. Peer reviews are overbearing and asking for additional criteria beyond their cited guidelines. On letter of medical necessity, X, the PA treating this patient acknowledged and addressed all these issues successfully. X is medically necessary. X is certified

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

Thoroughly reviewed provided records including peer reviews. Patient with chronic pain issues and has resorted to X. Peer reviews are overbearing and asking for additional criteria beyond their cited guidelines. On letter of medical necessity, X, the PA treating this patient acknowledged and addressed all these issues successfully. X is medically necessary. X is 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**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **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**

☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**