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Notice of Independent Review Decision

x

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 X. X was working X. The diagnoses were sprain of ligaments of lumbar spine (X) and muscle spasm of back (X).On X, X was seen by X, PA for follow-up visit. At the time, X followed up in clinic from X prior visit on X. X was X on X with X. X reported feeling discomfort and pain since the cold front which occurred a few weeks prior. X noted having increased back spasms especially when the weather changes. X wanted to alleviate X ongoing pain symptoms with a X as this provided significant relief in the past. X continued X . X denied having any neurological changes, bladder / bowel changes, or saddle paresthesia. The prior history included that X was referred by Dr. X and Dr. X in the past for X. X was last seen on X so X presented to get reestablished and also reviewed the MRI findings. X had a recurrence of this pain symptoms which stemmed from a work-related injury on X. X was working X. X had multiple X. X also ended with what sounded like X in X by Dr. X. X described aching and stabbing pain in X right back included the pain radiated down the right posterior calf into the right foot and X rated it up to X and worsened since X procedure had been denied multiple times. X had tried and X. X had also X. On examination, blood pressure was 127/78 mmHg, weight was 248 pounds and body mass index (BMI) was 31 kg/m2. Lumbar / lumbosacral spine examination revealed X. Sensation was X. X was advised to X. X was recommended. X were continued. The assessment and plan was discussed with Dr. X. An MRI of lumbar spine dated X revealed at X. The X was seen. There was X. The X was X. The X were patent. At X was present. X was seen. There was X present. There was X. There was X present. The X was X. X was X. The X was patent. At X. There was X. X was seen. There was X. The previous X was noted. The X was X. The X were X. Treatment to date included X. Per a utilization review adverse determination letter and peer review report dated X by X, MD, the request for X was denied. Rationale: “Per ODG Low Back guidelines regarding criteria for X, "X may be indicated when ALL of the following are present X." In this case, regardless of the benefits from the prior X MRI revealed only X. The request is not shown to be medically necessary. Therefore, the request for X is non-

certified. “Per a reconsideration / utilization review adverse determination letter / peer review report dated X by X MD, the request for X was denied. Rationale: “ODG by MCG Pain (Updated: X) X. ODG Criteria X. Procedure performed X: The X" In this case, the patient has low back pain that is aching and stabbing in the right back that radiates down the right posterior calf and right foot. The patient X. The patient had a X on X with X. The patient reports increased symptoms due to the cold weather change. The exam showed X. Decreased sensation to X. X SLR on the right. MRI of the lumbar spine dated X showed X. The plan is for a X. Given that there is X, the request is supported. However, the request for the X is not supported by the referenced guidelines. As there was no peer-to-peer discussion to modify this request without sedation, the request is not medically necessary. Therefore, the request for X by Dr. X, DO is upheld and non-certified “Thoroughly reviewed provided records including peer reviews. Patient with X. Had prior X. The request meets ODG criteria for X. X may be used to help with patient tolerance and is not a significant variance from the cited guidelines (X). X by Dr. X, DO 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 peer reviews. Patient with X. Had prior success with X. The request meets ODG criteria for X. X may be used to help with patient tolerance and is not a significant variance from the cited guidelines (X). X by Dr. X, DO 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