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Notice of Independent Review Decision

Amendment X

IRO REVIEWER REPORT

Date: X; Amendment 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 at work on X. X stated X tried X. The diagnosis was sprain of ligaments of lumbar spine, subsequent encounter (S33.XX).On X, X was seen by X, MD for a follow-up of low back pain. X had continued low back pain which radiated to right lower extremity. X described the pain as constant with pins and needles. X rated the pain X ongoing and at best, and X at worst. The pain was aggravated by standing and alleviated by rest and medication. Examination revealed X. There were X present. There was X. There was X at X. There was X. X was X on the right at X degrees and on left at X degrees. There was X left flexion, abduction, and external rotation (FABER) test. X was present. There was X present. Motor function revealed strength of X in right hip flexion, right knee extension, dorsiflexion, plantar flexion, and extensor hallucis longus (EHL) and X in left hip flexion. Sensory exam showed X. X had the most relief with X. At the time, that pain was on the left. Left X was ordered. On X, X was seen by X, DO / Dr. X for chief complaint of low back pain. X presented for a follow-up visit related to work comp injury. X continued to complain of low back pain with radiating pain. At the time, X rated pain as X, at best and at worst X. The nature of pain was like pins and needles, radiating to right lower extremity, constant. It was aggravated by standing and alleviated by rest and medication. On examination, X blood pressure was 174/105 mmHg, weight was 389 pounds and body mass index (BMI) was 60.9 kg/m2. Physical examination revealed X. Lumbar spine examination revealed X. Lumbar curvature was X. X were present at X. Lumbar range of motion (ROM) was painful with flexion / extension, bilateral rotation, and lateral flexions. X was present at X. X

was present X. X was X on the right at X degrees and left at X degrees. X was X on the left. X was X on the right and left. X was present on the left, improved on the right. Motor function on the right was X at hip flexion, knee extension, dorsiflexion, planter flexion and extensor hallucis longus (EHL) and on left was X at hip flexion. There was X. An MRI of the lumbar spine dated X revealed X. There was X. There was X. X had severe X. X had the most relief with X. At the time, the pain was on the left. They ordered X, which was denied. An MRI of the lumbar spine dated X revealed at X. The spinal canal was X. At X. This finding may X. There was X. At X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Regarding left X. Recommended on a case-by-case basis as X. Regarding fluoroscopic guidance, the Official Disability Guidelines do not offer recommendations. Therefore, alternative guidelines were referenced. An article from X. Per review of the medical report and the cited guidelines, the request is not supported at this time. There were prior non-certification of X on X. A prior review on file under X was certified on X for diagnostic purposes. The claimant had low back pain that radiated to their right lower extremity. They also have X. Their previous X. The cited guideline state that it is X. Given the above information, the prospective request for X is non-certified.”On X, Dr. X wrote an appeal letter and stated that the letter was in regards to X and the denial of a recommended X. Dr. X and X colleagues had been conservatively treating X for the past X years for complaints related to a work injury sustained while X on X. X had undergone X. These procedures had consisted of X in X that X was doing well. On X in which X reported a X. X also had a previous history of lumbar spine fusion in X by Dr. X and also performed a spinal cord stimulator trial on X. X last presented in office on X for a follow-up evaluation complaining of pain which X rated an X in intensity, particularly on the left lumbosacral region in the area of X. X physical examination remained consistent with X reported pain complaints by indicating a X. X lumbar curvature with X.

There was X. X had a X. X was X on the left, X tenderness bilaterally, X tenderness bilaterally, left greater than right, X on the left, X on the left, and X on the left. X most recent MRI of the lumbar spine was performed on X which showed X. A X. Minimal X at the remaining levels without significant areas of X was noted. Dr. X opined that X had met medically reasonable and necessary criteria for the approval of a left-sided X. This criteria included X subjective pain complaints, clinical objective findings on physical examination, benefit from X. The goal was to provide X with the relief necessary for X to be able to perform X activities of daily living as well as improve the overall quality of X life. Dr. X felt that X sacroiliac joint pain was a direct result of X work injury due to X. Dr. X felt that another X. Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The prior non-certification for the request of X in review X on X was based on the fact that clinical findings were not compliant with the guideline criteria as well as there were no extenuating circumstances that would allow deviation from the guidelines. Per the submitted documents, the request for X is not supported. The guideline indicates X and is generally not X. An appeal was submitted by Dr. X stating the medical necessity of the procedure based on the benefits from X. Although X, the request is not warranted due to a lack of documentation of significant factors to deviate from the guideline recommendation as well and there is no indication to X. Therefore, the appeal request for X is non-certified. Thoroughly reviewed provided documentation including peer reviews. While the cited ODG criteria X. Requested procedure is warranted as variance to the cited guidelines. In contrast, the provider's request is well within Medicare guidelines for X. 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 documentation including peer reviews. While the cited ODG criteria X. Requested procedure is warranted as variance to the cited guidelines. In contrast, the provider's request is well within Medicare guidelines for X. 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