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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 X. X reported that X. The diagnosis was strain of muscle, fascia and tendon of lower back, initial encounter (X).On X, X was evaluated by X,

MD for follow-up visit of low back pain. X reported X was able to stand for less than X minutes, sit for more than X minutes, and walk for less than X minutes. At the time, pain level was X; pain level at the worst was X and pain level at best was X. The pain felt like constant shooting, burning, throbbing, and stiffness. The pain felt better with rest. X underwent X. X reported improvement in overall pain by greater than X after the procedure. X was able to stand longer, sit longer, and sleep better with decreased pain medicine. There were no side effects noted. X was having pain again and would like another X. X was working with full duty. On examination, blood pressure was 139/80 mmHg. Physical examination revealed X was awake, oriented times three; was in no acute distress. There was X. The plan was to proceed with X. X had a degree of anxiety about needles, so the procedure with anesthesia was advised. An MRI of the lumbar spine without contrast dated X. There was no basis for X. Borderline narrowed configuration of the X. Facet hypertrophy and thickening of the ligamentum flavum contributed to narrowing of the subarticular recesses and spinal canal without apparent severe stenosis. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Official Disability Guidelines recommend X as indicated by the guidelines for carefully selected patients with proven lumbar facet joint mediated pain, following positive X. On X, the claimant presented with low back pain. Pain level was X. They are status X on X and reported overall improvement in pain by greater than X after the procedure. X was able to stand and sit longer and sleep better. There was a decrease in pain medicine. No side effects were noted. They are having pain again and would like another X. Lumbar spine examination showed X. Guidelines do not recommend X. As such, the medical necessity has not been established for the Request for X.” Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Per Official Disability Guidelines by MCG (ODG X, "Should not be repeated within X months of the primary procedure, and then only with >= X pain relief lasting >= X weeks (max 2 procedures per year). In this case, although the patient reported X pain reduction after previous X. As such, the request is not shown to be medically necessary and is non-certified. ODG guidelines are clear in recommending that this procedure should not be repeated within X months. Despite the success of the first procedure, a repeat procedure is not indicated at this time. 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:

ODG guidelines are clear in recommending that this procedure should not be repeated within X months. Despite the success of the first procedure, a repeat procedure is not indicated at this time 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