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Notice of Independent Review Decision

Amendment X

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IRO REVIEWER REPORT

Date:X; AmendmentX; 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 on X. The biomechanics of the injury was not found in the available record. The diagnoses included lumbar spondylosis and lumbosacral disc disease. On X, X was seen by X, MD in a follow-up visit for a routine X -month check in regards to X back pain and leg pain. X noted that the pain was better than it was before but X continued to have pain in the back and in to the right hip region. At night, X pain kept X from getting comfortable and in the morning X pain was at its worse. X took X. The pain in X back was dull, aching, and throbbing type of pain. X had a previous X. X did pretty well from that and got X better but at the time, the progressive degenerate changes at the level below had hindered X ability to completely recover. X had back pain which was going down into X leg. The leg pain had improved on the right but the back pain had not. It was worse when X lied down or when X tried to move in the bed. Activity made X pain worse. X refused to X. On examination, X weight was 219.5 pounds and body mass index (BMI) was 29.77 kg/m2. X had X, flexed on right side. Rest of examination findings were within normal limits. X had progressive low back pain which had become more disabling. X took X medications, but this was very limited. X mobility in X activity level had been impaired because of the progressive back pain. An anterior lumbar interbody fusion at X was discussed. X had a previous X. X last X was over X months prior, therefore a new X in addition to the X of the lumbar spine would be needed. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was non-certified. Rationale for X: “Per ODG, "Recommended for limited indications below. X has largely replaced X." The patient is having ongoing pain with limitations after surgery. Surgeon believes that the patient may need X. Therefore, imaging follow-up would be necessary to evaluate the X. In this case X would not be appropriate methodology. X would be the gold standard at this time. X may potentially be excessive. As such, this request is not certified.” Rationale for X: “Per ODG, "X" The patient is having ongoing pain with limitations after surgery. The surgeon

believes that the patient may need X. Therefore, imaging follow-up would be necessary to evaluate the X. X would be the gold standard at this time. However, as this is a Texas case, it cannot be certified without successful provider contact. As such, this request is not certified. “On X, an appeal was requested for X. Per a reconsideration / utilization review adverse determination letter dated X, X, MD non-certified the appeal request for X. Rationale for X: “Per ODG, "X. X has improved imaging in the presence of X. X should be the initial imaging choice for X," X of lumber spine is requested because the patient has prior history of X. Therefore, the request is not certified.” Rationale For X: “Per ODG, "Repeat X is recommended to determine next treatment steps if there is evidence of significant change in symptoms or findings suggestive of significant new pathology (X)." Records show that the patient had a lumbar X months before and the results are not provided. There is no evidence that anything has changed in the previous X months, therefore a X is not medically necessary and the request is not certified. “Thoroughly reviewed supplied documentation including provider notes, peer reviews. No imaging results supplied. Patient improving subjectively based on provider note in terms of pain, function, but still limited thus provider considering surgical intervention. However, has had prior X thus unclear why would need new X of lumbar spine without notable new symptoms or exam findings. Neither X of lumbar spine are indicated. 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:

Thoroughly reviewed supplied documentation including provider notes, peer reviews. No imaging results supplied. Patient improving subjectively based on provider note in terms of pain, function, but still limited thus provider considering surgical intervention. However, has had prior X thus unclear why would need new X of lumbar spine without notable new symptoms or exam findings. Neither X of lumbar spine are indicated. 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