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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]:

Patient Clinical History (Summary)X who was injured on X. X slipped on X. The diagnosis was sprain of an unspecified site of left knee, initial encounter (X); lateral epicondylitis, left elbow (X), and other intervertebral disc degeneration, lumbar region (X). X was seen by X, MD on X for reevaluation with respect to a work-related injury sustained while working for X. X reported X felt worse. X was X. X rated the pain as X. X was unable to work at the time. X was status post left upper extremity surgery. X endorsed standing still, sitting for long periods made the pain worse, and lying down made it better. There were no new symptoms. X reported X was following the treatment plan, which was helping. X had X. X had X. X had MRIs. Examination of the lumbar spine showed X. X raise was X. X wore a cast for X left upper extremity because of X. At that point, Dr. X would appeal the denial of the X and noted X may also be a candidate for X. X would talk to Dr. X regarding the X. An MRI of the lumbar spine dated X showed X. Mild disc bulging at other levels was favored to be chronic. There was X. X was noted at a few levels. There was no X. Treatment to date included X. Per a peer review dated X by X, MD, and a utilization review dated X, the request for X was denied as not medically necessary. Rationale: “The Official Disability Guidelines discusses X. This may be an option for patients with suspected X. The medical records in this case do not document X. Rather, the medical record consistently diagnoses the injured worker with X. Therefore, the request is not medically necessary and should be non authorized.” Per a peer review dated X and a utilization review adverse determination letter dated X by X, MD, the appeal request for X was denied as not medically necessary. Rationale: “In this injured worker, documentation does not support that injured worker’s low back pain is largely coming from the X origin. Additionally, there is a lack of substantial documentation to support response on variable factors required to proceed to X. Finally, this procedure is still considered experimental given conflicting scientific evidence. As such, the requested X

is not medically necessary and not according to the medical standard of care.” Thoroughly reviewed provided records including peer reviews. Patient had X. Per the cited ODG criteria from peer reviews, proceeding to is indicated. Though the provider still is using diagnoses of lumbar strain, as well as left upper limb radial nerve lesion, the patient is describing facet mediated pain and appropriate exam was also performed. X between X is medically necessary and certified

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

Patient had X prior with the provider documented 90% relief from pain. Per the cited ODG criteria from peer reviews, proceeding to radiofrequency ablation is indicated. Though the provider still is using diagnoses of lumbar strain, as well as left upper limb radial nerve lesion, the patient is describing facet mediated pain and appropriate exam was also performed. 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