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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 Overtuned 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 X. The diagnosis was complex regional pain syndrome I of unspecified lower limb. X was seen by X, DO on X for a follow-up. X continued to do well with a combination of X. X had lost over X pounds over the prior year. X was more functional and more active. X medication use had diminished orally. X was taking X. With the assistance of the X. X was getting excellent X. A X was X. Following that, a new solution of X. The X was X, giving X an alarm date of X. Under ultrasound guidance, X was noted either preprocedural or post procedure. Then X minutes after the procedure, X was alert and oriented. X vitals were stable and blood pressure was recorded. X was discharged in stable and satisfactory condition. X had a follow-up with X, DO on X. X had hurt X foot at work where the compensable injury was X left foot and ankle pain, which despite appropriate surgical, rehabilitative and medical treatment options developed complex regional pain syndrome in the severe state. It was at X. X ultimately required an X , which had given X sustained quality of pain relief, and improved the function, return to work duties and activities of daily living. X had been on a steady state level of X. X presented for a refill. Dr. X opined the peer doctor had done a disservice to X and secondarily may have increased healthcare cost by denying the reasonable necessary steady state treatment, which was proven efficacious consistent with the Texas Labor Code, which stated the patients were due treatment X. X was off X. The denial of this care could lead to X. X had developed trust and improvement of X quality of life with the care and as a result, X would have to be rescheduled. X was requested to visit the local emergency room and receive X. On X, X presented to Dr. X for further care regarding X chronic pain complaints effectively X. A new X. The X. That gave X an alarm date of X. Then X minutes after the procedure, X was alert and oriented. X vitals were stable. X blood pressure was recorded. X affect had improved accordingly. X daytime energy had improved. X was thankful for the progress made. X was discharged in stable and satisfactory condition. Per an addendum, with the assistance of the X. The X were unable to X. Attempts were made to X. X safely and effectively. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was noncertified. Rationale: “Per ODG, regarding implantable drug-delivery systems, "If treatment is determined to be medically necessary, as with all other treatment modalities, the efficacy and continued need

for this intervention and refills should be periodically reassessed and documented." The patient is a X who sustained an injury on X. In this case, the treating physician has not documented any specific improvements In pain or function 'that might be X. The request is not shown to be medically necessary. Therefore, the request for an X is non-authorized. “Per a reconsideration review adverse determination letter dated X, the request for X was noncertified. Rationale: “Official Disability Guidelines conditionally recommend X. Per Follow-up Note dated X, the claimant had been a patient for over X years in which time, X hurt X foot at work. Despite appropriate surgical, rehabilitative, and medical treatment, X developed complex regional pain syndrome in a severe state. It was at least X. X ultimately required an X. X has been in a steady state with no side effects. A prior review dated X non-certified the request for X. In this case, there is documented X. However, the provider is requesting X. As such, the medical necessity has not been established for the Reconsideration Request for X. “Based on review of the provided records, including provider documentation and peer reviews, the request is supported. The provider is seeing the claimant regularly and there is documented relief of pain and increase in function attributable to ongoing X. The provider notes the claimant has been on a steady state level of X. X was taking X. Based on these findings the request for X. Per the referral form, “X has X. X routine X are done in office. X was scheduled for X with alarm date X. We requested X.” is medically necessary and certified

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

Based on review of the provided records, including provider documentation and peer reviews, the request is supported. The provider is seeing the claimant regularly and there is documented relief of pain and increase in function attributable to X. The provider notes the claimant has been on a steady state X. X was taking X. Based on these findings the request for X. CPT codes X. Per the referral form, “X has X. X are done in office. X was scheduled for X with alarm date X. We requested 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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**