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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 is a X who was injured on X. X had a work-related injury which occurred while employed by X. The diagnosis was chronic pain syndrome and other low back pain. On X, X was seen by X, PA-C for a follow-up visit. X had a history of low back and bilateral lateral thigh pain. X had history of X. X lumber surgery inclusive of X. X pain and subsequent lumbar surgery were as a result of a work-related injury that occurred on X. X had a X in place. X had an X as well. Per Dr. X, X was prescribed X for breakthrough pain. The medication helped with X pain as well as X. X was not receiving X. Via the aid of X, X was able to interact with others, including X husband. X was able to complete X activities of daily living (ADL's). X rated pain X. On examination, X blood pressure was 125/83 mmHg, weight was 193 pounds and BMI was 31.15 kg/m2. Musculoskeletal examination revealed X. The treatment plan was for X. On X, X was seen by X, PA-C for a follow-up. X had history of X. X had history of X. X lumber surgery inclusive of X. Per Dr. X , X was prescribed X. The medication helped with X pain as well as X physical and psychosocial functioning. X was not receiving X. Via the aid of, X was able to interact with others, including X husband. X was able to complete X activities of daily living (ADL's). X was recommended for X, however, this was not approved by X Worker's Compensation insurance company. The procedure was of medical necessity and thus the request would be resubmitted. X rated pain X. On examination, blood pressure was 125/76 mmHg, weight was 193 pounds and BMI was 31.15 kg/m2. Musculoskeletal examination revealed X. X ambulated with X. X had decreased X. X had decreased X. X had X. The treatment plan was unchanged with X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X MD, the request for X between X was denied. Rationale: "In this case, there is no physical examination with objective radiculopathy. Subjective symptoms are not consistent with radicular pain. As such, the request for X is not medically necessary. "On X, X, MD provided an expedited appeal request for X stating that medical documentation provided that

showed physical examination with objective radiculopathy. Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X between X was denied. Rationale: “In this case, there is no documented evidence of X. There is also no record of advanced imaging of the lumbar spine. Therefore, the appeal request for X is not medically necessary. Thoroughly reviewed provided records. Provider seeing patient requested X given had improvement with X. Peer reviews state that there is no subjective complaints or objective findings consistent with radiculopathy. However, it is clearly stated in multiple notes that patient had radiating pain from back into bilateral lower extremities. Further, physical exam notes allodynia in bilateral lower extremities. Even so, there is no satisfactory explanation as to why patient should get X. There is no subjective complaints of increased pain, or worsening exam or functional findings. Patient has not had documented recent physical therapy. Patient also had prior surgery in this area and has spinal cord stimulator for which X would be unlikely to be effective based on medical evidence. Requested X is not warranted. X between 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:

Provider seeing patient requested X given had improvement with X. Peer reviews state that there is no subjective complaints or objective findings consistent with radiculopathy. However, it is clearly stated in multiple notes that patient had radiating pain from back into bilateral lower extremities. Further, physical exam notes allodynia in bilateral lower extremities. Even so, there is no satisfactory explanation as to why patient should get X at present. There is no subjective complaint of increased pain, or worsening exam or functional findings. Patient has not had documented X. Patient also had prior X in this area and has X for which X would be unlikely to be effective based on medical evidence. Requested X is not warranted. X between 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