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Notice of Independent Review Decision

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: PM&R/Pain Medicine

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 at work on X when X was " X. The biomechanics of injury were largely illegible due to poor scanning. The diagnosis was lumbar laminectomy syndrome, sprain of ligaments of lumbar spine and chronic pain syndrome. On X, X was evaluated by X, MD for a follow-up and X. X presented with complaints of pain in the low back, left leg, mid back and buttock. X described the pain as X. The pain was X. The pain was better with X. The pain level without medication was X and with medication X. X presented for follow-up and X. X continued with pain in the low back radiating down the left leg in the X. Because of X abandoned stimulator device, which Dr. X had looked at under fluoroscopic guidance and could not discern what type of device it was, X did not recommend an updated MRI at the time. X walked with a X. X was having X. X symptoms responded favorably to an X back in X, and the leg symptoms in particular had X reversal. The symptoms started to return about X months after that, and they were back to baseline by the X-month mark. Dr. X had attempted to order a X. They stated that X previous X had not provided objective proof of benefit. Dr. X reviewed the previous notes again and noted X post-up follow-ups had demonstrated X relief of the symptoms in the legs, and X pain score was reported as X at the X-week mark and X at the X-week mark. The symptoms did not return to X or higher in intensity until greater than X months out from the procedure. X said that Dr. X was definitely the person who did the X. X needed a refill of X pain medication and X and stated that the medication provided X. On examination, weight was 219 pounds, BMI 32.34 kg/m2 and blood pressure was 142/72 mmHg. The abdomen revealed X. The lumbar spine examination revealed X. There was X present on the right and left side. The X was limited in flexion, extension, lateral bending to right and left, and lateral rotation to the right and left. X loading test and X test on the left were noted. The X was X on both sides. The X was X, with X. The assessment was X. X, X and X were refilled unchanged. They would either appeal or re-order the X. It was noted that X left leg symptoms had worsened. X had excellent relief of the symptoms for up to X months with previous most recent X. X had even longer duration of benefit at times with previous X. X would be referred to Dr. X for evaluation and treatment of abandoned stimulator leads. Until then, Dr. X did not recommend updated imaging due to questions of MRI compatibility and potential for harm. It was also possible that the device itself could be causing X. Treatment to date included X in X, surgical intervention (X on X; X at same level on X; and X on X. Per a utilization

review adverse determination letter dated X by X, MD, the prospective request for X was denied. Rationale: “In this case, the X. Furthermore, there is no evidence of objective functional gains since the prior X, and the X records show reports of X pain one-month post-X. Therefore, the request for X is non-certified. “On X, X from Dr. X office appealed the denial of the request for X. The denial stated, “…there is no evidence of objective functional gains since the prior X, and the X records show reports of X pain one-month post-X. Therefore, the request for X is non-certified.” Dr. X wrote, “I am enclosing a copy of the most recent office visit dated, X in which the postop findings from the pt's last X "demonstrated X relief of the symptoms in the legs, and X pain score was reported as X out of X at the X-week mark and X out of X at the X-week mark. The symptoms did not return to X out of X or higher in intensity until greater than X months out from the procedure." Of importance to note is the fact that the X office visit (as well as every medication management office visit) asks for a pain level WITHOUT medication and WITH medication. X “9/10 pain one-month post-injection” that you reference is X answer to X pain level WITHOUT medication. X answer to X pain level WITH medication was X out X.” Per a reconsideration review adverse determination letter and a peer review dated X, by X, MD, the appeal request for X was denied. Rationale: “In this case, the injured worker complains of increased lower back pain with radiation into the left, which is more significant than the right lower extremity. There is more X to the right greater than left lower extremity, and a X is required for X. Physical examination of the lumbar spine reveals a X. The injured worker's X is limited. X on the right and left, X on the left, X to both sides. X is X with a X. There was no documentation of decreased medication requirement as required by the guidelines after the previous procedure. Therefore, the appeal request for X is noncertified. “Thoroughly reviewed provided documentation including provider notes and peer reviews. Patient had prior success with prior X. Though reviewers question pain relief with or without medication, or if patient had decreased pain medication use, these are not major requirements for X. Patient with complex pain syndrome as evidenced by failure of conservative and invasive treatment options. Proceeding to perform requested injection is warranted and reasonable. X is medically necessary and certified

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

Thoroughly reviewed provided documentation including provider notes and peer reviews. Patient had prior success with prior X. Though reviewers question pain relief with or without medication, or if patient had decreased pain medication use, these are not major requirements for X. Patient with complex pain syndrome as evidenced by failure of conservative and invasive treatment options. Proceeding to perform requested X is warranted and reasonable. 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)**