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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 who sustained an injury on X. At work, X was X. The diagnoses included chronic back pain syndrome with right lumbar radiculopathy following a work injury and lumbar disk herniation at X.X underwent X by X, DO on X. The preoperative and postoperative diagnoses included chronic back pain syndrome with right lumbar radiculopathy following a work injury and lumbar disk herniation at X. On X, X reported a X improvement in X back and buttock pain and complete relief of X leg pain complaints following the X. X gained some X. At the time of the visit, X felt the pain was just gradually starting to come back, but X continued to be X improved. X was walking and exercising. X continued to have some numbness and weakness in X right leg, much improved. X rated X pain X. X had reduced X. X was walking longer distances. X was satisfactory. X was getting exercise and rehabilitative care with Dr. X. X needed to be fully recovered before returning to work whereby X required heavy lifting, bending, and twisting throughout the day. On X, X presented disappointed. X got excellent relief from pain. X pain started to come back. The X gave X more than X relief of pain at the X. X continued to have buttock pain, radiating down X right leg, but not as severe as initially presented. X formerly enjoyed X work and wanted to get back to X former levels of activity both at home and at work. On examination, X was X at X degrees; hamstring tightness; contralateral straight leg X degrees on the right with a decreased pinprick in the X; and X unremarkable. X noted bigger pain was down the back of X right leg, in the X. The X was recommended due to the persistent nature of X pain; and more than X for over X. Due to the X, X would require X. Dr. X did not want X moving. Movements lead to morbidity. X wanted to lower morbidity, lower healthcare costs, and improve outcomes. The treatment success had a post dural puncture headache of less than X, when nationally any academic institution would show a X in X incident rate of X. Dr. X attributed that to X skill and X. An MRI of the lumbar spine on X showed X. Treatment to date included X. Per the utilization review by X, MD on X, the request for

prospective request for X was non-certified. Rationale: “The records provided do not document that the injured worker has a recurrence of their radicular pain specifically nor is there an indication that radiculopathy prevents meaningful participation in active rehab efforts. There is X. Based on the information available, the request is not shown to be supported by the ODG or be otherwise medically necessary. Therefore, the request for X is non-certified. “Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “In the case, the injured worker reported X or more improvement for one month and an unclear degree of residual improvement for 2 months after the X. There is no record of objective functional gains. Moreover, the guidelines do not recommend X. The request form includes a request for X. Monitored X would not be needed to X. The request is not shown to be medically necessary. Therefore, the request for X. “Patient with acute return or exacerbation of radicular pain for which provider is seeking repeat X. Patient had success from X. Patient meets cited ODG criteria and concerns raised by peer reviews are not valid given documentation supplied. X requested is also warranted given documented X. X is medically necessary and certified

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

Patient with acute return or exacerbation of radicular pain for which provider is seeking X. Patient had success from X. Patient meets cited ODG criteria and concerns raised by peer reviews are not valid given documentation supplied. X requested is also warranted given documented X. 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