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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. The mechanism of injury was not available in the provided medical records. The diagnosis was radiculopathy, cervical region (M54.12).X was seen by X, MD on X for neck pain and headaches. X reported being able to stand for less than X minutes, sit for less than X minutes, and walk for less than X minutes. The pain score was X. The pain level at the worst was X and pain level at best X. X felt constant, aching, and stabbing pain. The pain felt better by rest. No significant changes were noted since the prior visit. On examination, X blood pressure was 195/117 mmHg, heart rate was 90 beats per minute (bpm), and oxygen saturation was 98%. X was awake, oriented times three, and in no acute distress. It was noted there were no significant changes in the physical examination since the prior office visit. (A visit note dated X revealed examination findings of neck range of motion showing decreased flexion, decreased extension, and decreased looking to the right and to the left. The most recent office visit with examination findings was on X and showed motor in the upper extremities of X.) The diagnoses were post laminectomy syndrome, not elsewhere classified; and chronic pain syndrome. A X was performed with X. X was discharged in stable condition. X was advised to follow-up at this clinic as needed, for a repeat procedure, and for reevaluation. A X dated X revealed X. There was X at X and X at X. There was X. There was X. There was X. X in reference to the X. There was X. There was X. There were X. X was seen appearing to X. X was seen at these levels. Treatment to date included X. Per a peer review dated X and utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “This is non-authorized. The request for X is not medically necessary. The history and documentation do not objectively

support the request for. The ODG state “ODG, X for Pain. Conditionally Recommended. X : X according to instructions programmed by the X. The time between X. A X, which may occur along with or X. If X are usually administered after X. Given that a X.” In this case, clear objective evidence of benefit including pain relief and functional improvement with X was not submitted. The injured worker’s current physical findings are unknown. The medical necessity of this request has not clearly been demonstrated. A clarification was not obtained. “Per a reconsideration review adverse determination letter dated X by X, MD; the prior denial was upheld. Rationale: “This is non-authorized. The appeal request for X is not medically necessary. This method of treatment may be of benefit, however, there is no recent supportive objective findings to support medical necessity of the request. Most recent treatment note reports no specifics in terms of objective measured functional gains or extent of pain benefit with the X. Pain levels from recent notes continue to report severe pain X. Thoroughly reviewed provided records including peer reviews. While patient may be having some benefit from X.” However, the patient does have some pain relief with pain going down to X and sometimes up to X. Pain is a complex phenomenon and as patient has tried multiple methods of pain relief before resorting to X. As both patient and provider both want to continue with X. 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 records including peer reviews. While patient may be having some benefit from X.” However, the patient does have some pain relief with pain going down to X and sometimes up to X. Pain is a complex phenomenon and as patient has tried multiple

methods of pain relief before resorting to X. As both patient and provider both want to continue with 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

☒ 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)**