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An Independent Review Organization
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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 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. X twisted X back and reported to have suffered "X. The diagnosis was M25.50 (pain in unspecified joint).X was seen by X, DO on X for a follow-up. X was walking with an X. X had a X. X had X. Dr. X had helped X lose over X pounds. X was X. Interventional pain care over X months prior got X more than X pain relief and helped lessen the X. X was incidentally also taking X. A X was recommended. That treatment had proven timely, effective and without side effect. The Texas Labor Code supported intervention in lieu of the opioid epidemic. Dr. X further documented "The Texas Labor Code states that treatment, which ameliorates or relieves the natural compensable disease state is due to this gentleman under Texas Department of Insurance guidelines and state law." Further delays would only lead to refractory and costly complaints with further disability. X urinalysis study was consistent with the agents X was reporting. X was satisfactory and a X would be arranged, pending insurance authorization. X consulted X, DO on X for complaints of chronic left hip and buttock pain. Over the X years or so, X had received more than X improvement of X pain utilizing X. Dr X had enhanced all things and encouraged to the care including alternative X. Initially, X was on X. X was down to X. On the day of the visit, X reported feeling X was returning. X had tenderness at that site. X had positive rocking sign. X had X. That was all the same pain that X had initially visited X. The most recent X was over X years. X got more than X months of continuous pain relief allowing more function. X was more active and had not raised X oral medications. X was quite emotional and distort that

this treatment, which had proven itself effective was not being approved. Due to X. That was a time proven effective treatment consisting with the Texas Labor Code, which specifically stated “the patients are do treatment which ameliorates or relieves the natural compensable disease state.” Further delays would cause refractory and costly pain complaints. X had a follow-up with Dr. X on X. The note indicated no more than X had helped X dramatically recover in conjunction with X. X had lost weight and was exercising. X sleep had improved. X reported stabbing pain in the X. On examination, X had a X. This was X. Per Dr. X, X had done well with more than X relief of pain, improved function and further reduction and medications with this treatment. A urine drug screen dated X was X. An MRI of the lumbar spine dated X showed X. Posterior central and left paramedian X. Mild broad based posterior hard disc bulge was noted at X. At X, the disc was mildly narrowed and moderately desiccated. There was X. At X, the disc was mildly to moderately desiccated. There was a X. A CT scan of the lumbar spine status post lumbar discogram dated X (unclear date) showed X. Treatment to date included X. Per a utilization review adverse determination letter and a peer review report dated X by X, MD, the request for X was denied. Rationale: “Per the guidelines, X are recommended for treatment of X. They are not recommended for X. The records provided do not show that the injured worker has a X. In the absence of such evidence, the request is not shown to be supported by the aforementioned guidelines nor otherwise medically necessary. Additionally, the records provided indicate that the injured worker previously received a X. Based on the information provided, the request is not shown to be supported by the guidelines nor otherwise medically necessary. Therefore, the request of X is non-certified. “Per a reconsideration / utilization review adverse determination letter dated X and a peer review report dated X by X, MD, the request for X was denied. Rationale: “ODG guidelines do not support X. There is no

documented evidence of rheumatologic disease. Moreover, it is unclear why X would be needed for an X. The request is not shown to be medically necessary. Therefore, the appeal request of X is non-certified. "Thoroughly reviewed provided records including peer reviews. Patient had prior documented benefit from X. Now pain is returned in similar distribution and provider is requesting X. While the patient does not meet the cited ODG criteria to have an active rheumatologic/inflammatory issue affecting SI joint, given that the patient had prior success from same injection, as well as otherwise following accepted pain management practices, X appears warranted. Further patient meets other criteria such as from CMS. On the other hand, despite some documentation of patient's weight/weight loss. There is no absolute weight or BMI recorded, and even if supplied, unclear why patient would need X for this reason for this X requested is not indicated. X is medically necessary certified. X is not medically necessary not 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. Patient had prior documented benefit from X. Now pain is returned in similar distribution and provider is requesting same X. While the patient does not meet the cited ODG criteria to have an active X appears warranted. Further patient meets other criteria such as from CMS. On the other hand, despite some documentation of patient's weight/weight loss. There is no absolute weight or BMI recorded, and even if supplied, unclear why patient would need X for this reason for this X requested is not indicated. X is medically necessary certified. X is not medically necessary not certified Partially 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