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Notice of Independent Review Decision

Amended Letter x

IRO REVIEWER REPORT

Date: X; Amended 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 was injured on X. X was X. X slipped and fell backward and injured X low back, thoracic back, both knees, both ankles and left elbow. The diagnoses were sprain of ligaments of lumbar spine, contusion of unspecified back wall of thorax, lumbar sprain / strain. X was seen by X, MD on X for a re-evaluation with respect to a work-related injury sustained while working on X. X continued to have pain rated X. X was unable to work and had constant pain, which worsened by any activity and was better by lying down and resting. No new symptoms were noted. Following the treatment plan, which was helping, X was taking X. X had received X. X was X. X was X. On X, toe and heel walking was X. Flexion, extension, and rotation of the lumbosacral spine was X. X were noted at X, and also in the thoracic spine. X consulted Dr. X on X for complaints of upper back pain, which did not radiate. The pain had been ongoing on since the injury. It was described as aching, throbbing and constant. Treatments included medications including but not limited to X. X was working light duty. Examination showed tender facets at X. X was willing to proceed with X.X consulted X, MD on X for complaints of back pain, which was rated X. X had been working modified duty. X left elbow was doing better and X had no limitation of range of motion. X was doing therapy. X low back was not getting better and X continued to have severe pain. X had joined the X. X was also scheduled for the X. On examination of the thoracic spine, palpation revealed X. X was noted. There was full range of motion but flexion and extension was painful. X was intact X. Examination of the lumbosacral spine showed X. X revealed X. X was X. X was X. X was approximately X of the way toward meeting

the physical requirements of X job. An MRI of the thoracic and lumbar spine dated X demonstrated following thoracic findings: X. Nondisplaced fracture related to the trauma could not be excluded. X of the X. There was X. X at the X. X formation was present at other levels. X was noted at any level. X was noted. The X was X The lumbar findings were as follows: X. X at other levels was favored to be chronic. X or lateral recess X was noted at any level. There was X. X was noted. X was seen. Treatment to date included X. Per a utilization review adverse determination letter and a peer review report dated X by X, MD, the X was noncertified. Rationale: "The guidelines do not recommend X. In this case, although there is evidence of pain with palpation of the care is necessary for administering such X. There is X. Consequently, with imaging guidance and anesthesia, the request for X is non-certified. "Per a reconsideration utilization review adverse determination letter and a peer review report dated X by X, MD, the appeal request for X was noncertified. Rationale: In this case, the Official Disability Guidelines (ODG) do not recommend X. There are no documented extenuating circumstances to support an exception to the guidelines. This request is not shown to be medically necessary. Therefore, the appeal request for X is non-certified. "Thoroughly reviewed provided records including peer reviews. Noted that patient X. However, as peer reviews point out, because of limited evidence to support X, does not appear that requested X. No extenuating circumstances provided to X. Further, patient has existing radicular pain which could also be causing their back pain issues. In addition, there is no significant explanation to warrant use of requested X for this procedure. 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:

Thoroughly reviewed provided records including peer reviews. Noted

that patient with pain around X. However, as peer reviews point out, because of limited evidence to support X. No extenuating circumstances provided to X. Further, patient has existing radicular pain which could also be causing their back pain issues. In addition, there is no significant explanation to warrant use of requested X for this procedure. 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