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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 is a X who was injured on X. The biomechanics of the injury was not available in the provided records. The diagnosis included radiculopathy, lumbar region; post laminectomy syndrome, not elsewhere classified; chronic pain syndrome and sacroilitis, not elsewhere classified. On X, X was seen by X., DO for complaints of right lower back pain and posterior hip pain. Pain was described as a sharp, burning, deep, soreness and tightness in quality. X had right posterior leg pain to the knee. X symptoms were aggravated with sitting, driving, bending and standing. X had improvement with laying on X sides. X had greater than X pain relief and functional improvement (sitting, standing, walking and activities of daily living) with ongoing medications with no side effects. X admitted to right lower extremity weakness and denied bowel / bladder changes. Pain level was X. Examination of spine showed X. There was increased pain with lumbar flexion / extension. Tenderness was noted over X. X was noted. X were X. Muscle strength in right lower extremity was X with right hip flexion, knee extension, ankle dorsiflexion, plantar flexion, and EHL. X was noted in X. Deep tendon reflexes were X. X was noted. X was scheduled. X was recommended to X. X was recommended to X. X, X was seen by Dr. X for complaints of right lower back pain and posterior hip pain. Pain was described as a sharp, burning, deep, soreness and tightness in quality. X had right posterior / lateral leg pain to the foot. X symptoms were aggravated with sitting, driving, bending and standing. X had improvement with laying on X sides. X had greater than X pain relief and functional improvement (sitting, standing, walking and activities of daily living) with ongoing medications with no side effects. X admitted to right lower extremity weakness and denied bowel / bladder changes. Pain

was rated X. Examination of spine showed X. There was increased pain with lumbar flexion / extension. X was noted over X. X was noted. X were X. Muscle strength in right lower extremity was X with right hip flexion, knee extension, ankle dorsiflexion, plantar flexion, and EHL. X was noted X. Deep tendon reflexes were X. X was noted. X was scheduled. X was recommended to X. X was recommended to X. CT scan of the lumbar spine dated X showed X. X was noted. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was non certified. Rationale: “There is no report of acute neurological deficits regarding the injured workers chronic radiculopathy. There is no report of injured workers use of decreased medication from the last X. CT Scanning reports X. Exam reports X. Official Disability Guidelines (ODG), X. Per guideline, conditionally recommended as a short-term treatment for X. This treatment should be administered in X. Not recommended for treatment of X. X are not recommended as a treatment for X. X are not recommended. “Per an appeal letter dated X, Dr. X stated, “Based on the patient's history prior imaging, and current exam, the patient has X. X has completed X. The patient completed a X on X with greater than X pain relief and functional improvement for X. We are submitting this request to repeat this procedure to improve X radicular symptoms. This procedure is approved under ODG guidelines and is medically necessary. “Per a reconsideration review adverse determination letter dated X by X, DO, the request for X between X to X was non certified. Rationale: “According to X lumbar CT scan on X, there was of X at other levels per radiology report. According to an appeal letter by Dr. X on X, the injured worker has right-sided lower back pain and right posterior hip pain as well as right anterolateral leg pain to the knee and right lower extremity weakness and mention of symptoms aggravated with sitting, driving, bending, and standing and improved with laying on X sides. The injured worker has had a previous

right-sided X on X with reportedly X pain relief and functional improvement for X. The injured worker had previous X. The physical exam revealed X. The injured worker also had right-sided lumbar radiculopathy in the X. The plan is to repeat the X to improve X radicular symptoms. However, there was no documentation of the injured worker having a worsening lumbar radiculopathy condition occurring since the last X that is interfering with X baseline function. Also, previous lumbar CT imaging X. There was also no documentation detailing what specific overall functionality was achieved with the X. Therefore, given these circumstances and the guidelines, there is no support for the requested X, and this request is non-certified. Dr. X appeal letter on X summarizes points well and goes through ODG criteria for X. While peer reviews have valid points, they are beyond ODG criteria for X. Request for X is reasonable and necessary. X is medically necessary and certified

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

Dr. X appeal letter on X summarizes points well and goes through ODG criteria for X. While peer reviews have valid points, they are beyond ODG criteria for X. Request for X reasonable and necessary. 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)**