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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 while X. The diagnoses included chronic pain syndrome, chronic low back pain, prolapsed lumbar intervertebral disc, lumbar radiculopathy, and lumbosacral radiculopathy. X was evaluated by X, MD on X for lumbar spondylosis. X complained of low back and leg pain. X located X pain in the axial lumbar spine with aching pain alternating with sharp and spasming pain. X also described electrical sensations, tingling, and numbness in the legs / feet. X also noted weakness. The pain was aggravated by extension, flexion, rotation, walking, sitting, and standing. It was decreased with lying flat and rest. X reported X relief from the X on X for up to X week following the procedure, then had X for X weeks afterwards. X continued to have some mild to moderate relief with improved mobility and range of motion; however, X was starting to again had exacerbations of X pain like X did prior to Xand X pain was returning to baseline. X rated X ongoing pain X and without pain medications X. X body mass index was 38 kg/m² and blood pressure was 146/92 mmHg. X revealed X. Pain was reproduced with X. X was X. X were X. X were X. A letter by X, MD on X documented that "This Is a letter of medical necessity regarding the treatment of X. X has had significant relief and improvement with X quality of life from X. X is not interested in X. X has X." An MRI of the lumbar spine on X revealed at X. Treatment to date included X. Per the utilization review by X, DO on X, the request for X was non-certified. Rationale: "According to a lumbar spine MRI study on X. there was documentation at X. According to an office note by X, FNP-C on .X, there was documentation of the claimant having axial low back pain with referred pain to the left greater than right lower extremities as well as

numbness/tingling in the legs/feet. There was also documentation of previous treatment that included X. Work status was not listed. Physical exam revealed X. There was also documentation of diagnoses that included chronic pain syndrome, chronic low back pain, and lumbar/lumbosacral radiculopathy. The treatment plan included X However, there was no documentation detailing why a X is being requested particularly given the good response achieved from the X. As such, given these circumstances and the guidelines, there is no support for the requested X. Therefore, the request is not medically necessary. “Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “Per Official Disability Guidelines, Pain Chapter, Online Version (X), X "Conditionally Recommended as an option; may be a first-line or second-line option. ODG Criteria X: X." In this case, the patient’s physical examination did not document X. The patient had X on X and had X. The guidelines recommended more than X weeks benefits from X. However, there is no indication of more than X weeks benefits from the patient’s X. Therefore this request is not certified. “Thoroughly reviewed provided records including peer reviews. Patient had prior X. X of same sites is being requested because patient having exacerbations of pain issues. However, given had <X weeks of pain relief from X is not warranted based on cited guidelines. 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. Patient had X. X is being requested because patient having exacerbations of pain issues. However, given had <X weeks of pain relief from X is not warranted based on cited guidelines. 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