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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 biomechanics of the injury were not available in the provided records. The diagnoses were chronic pain syndrome, low back pain and lumbar radiculopathy. Per a case management note dated X by X, MD, X was injured when working. X had previously X. X had an X, which provided reasonably good pain relief but X continued to have X. X underwent a X. X would like to move forward with X. The plan was X. On X, Dr. X performed placement of X. The note indicated X had X.A X note was documented on X noting the percentage of general pain relief experienced was X. X experienced two days or more of pain relief. X had improvement in X activities of daily living. The X was successful. X wanted to proceed with X. A psychological testing was performed on X by X, PhD X was cleared for X. X had a good outcome and although X was still struggling with grief from the death X. X was seen by X, MD / Dr. X on X for a follow-up of chronic low back pain and lumbar radiculopathy stemming from a work accident. The pain was rated X. X had an X. That had helped with X pain. X was getting a X. Despite the X, X was still suffering with persistent lower extremity pain with burning in X feet. X had an MRI showing X. The X gave X. X was suffering with severe bilateral lower extremity and foot burning pain. X was taking X. X reported it was severely difficult for X to walk greater than five minutes. It was severely difficult to perform prolonged sitting. X could perform prolonged standing with moderate difficulty. X found it severely difficult to sleep. X could take personal care with moderate difficulty. X found it severely difficult to perform housework. On examination, BMI was 41.14kg/m2. X was in no acute distress (NAD). Musculoskeletal examination showed X. Neurological examination showed X. X was alert

and oriented times three. It was opined that X had near complete X. The plan was to try to perform a X. X wanted to avoid X. X and X via X were continued. An MRI of the lumbar spine dated X showed X. Overall, that did not appear to have significantly changed compared to study of X. There was suspected postoperative change, most consistent with a X. There was X. At the X, there was X. There was loss of the X. There was a X. The constellation of findings induced X. At the X, there was a X. At the X, there was a X. At the X, there was X. At the X, there was X. Treatment to date included X. Per a peer review report with referral date X by X, DO, the request for X was not medically necessary. Rationale: “According to a stimulator trial information form on X, there was listing of general pain of X relief achieved and experienced two days or more of pain relief and improvement with activities of daily living and the trial listed as successful with the plan to proceed with the X However, while there was documentation of improvement with activities of daily living with the X, there was no clear detail provided of how much activities of daily living improvement occurred from baseline and these was no documentation of what other functional improvement measures occurred. Also, an X should be used as part of a multidisciplinary treatment plan, which was not documented for this claimant and there was no documentation that the claimant is capable of operating the stimulating device. Therefore, X is not medically necessary. “Per a peer review report with referral date X by X, MD, the request for appeal X was not certified. Rationale: “Per ODG criteria, "X." In this case, the patient reported X pain relief but there is no record of corresponding functional gains during the spinal cord stimulator trial. The request is not shown to be medically necessary. Therefore, the request for X for low back is upheld. “Thoroughly reviewed provided records including peer reviews and imaging results. Patient had X. X appeared successful as patient had experienced X pain relief for over 2 days. The patient also noted functional improvement. ODG criteria cited by peer reviews has been met given >X improvement in pain and function documented. Thus,

placement of X is indicated. 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 and imaging results. Patient had X. Trial appeared successful as patient had experienced X pain relief for over 2 days. The patient also noted functional improvement. ODG criteria cited by peer reviews has been met given X improvement in pain and function documented. Thus, placement of X is indicated. 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)**