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Notice of Independent Review Decision

Amendment

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 working as a X, X was standing on a chair to get some materials off of a shelf when X leaned too far and fell and injured X lower back. The diagnoses included low back pain; chronic pain syndrome; compression fracture of body of thoracic vertebra; compression fracture of lumbar vertebra with delayed healing; long term (current) use of opiate analgesic; myalgia, other site; other intervertebral disc degeneration, lumbar region; other intervertebral disc displacement, lumbar region; other long term (current) drug therapy; other spondylosis, cervical region; post laminectomy syndrome; sacroiliitis, and trigger point of thoracic region. X was seen by X, MD on X and X for a medication refill. The diagnoses included chronic pain syndrome and low back pain. X was refilled. On X, X presented for low back pain, bilateral lumbar, and greater on the right. X reported the pain radiated throughout both lower extremities. It was described as constant with intermittent exacerbations, sharp, aching, and electrical shock, and rated X, unchanged from the prior visit. The symptom was improved with medications. The symptom was exacerbated by activity. X was taking X. X mentioned X pain started in the mornings, in the afternoon, and in the evenings. X was sleeping poorly and waking up multiple times throughout the night. X had an X. X reported 0% relief with X ongoing regimen and no side effects were reported. X blood pressure was 137/96 mmHg and X body mass index was 26.4 kg/m^2. On examination, X posture was stooped. X was walking slowly and slowly from a seated to a standing position. X was unsteady. X was wheelchair

bound. X pain was managed with a X. Overall, X was not stable. X described no significant change in pain, mobility, and / or functionality. X lumbar pain complaints were not under control. Due to concern for lack of control with X, the plan was to start weaning the medication down and reassess if there had been prior benefit. X medication regimen was reviewed. X described no side effects with the ongoing regimen. The plan was to make change in medication recommendations. Due to X history, ongoing use of X. X reported that pain did increase after X was decreased, X. On X, X was refilled. Per the prior review dated X, EMG on X revealed electrodiagnostic evidence of severe X. Per the note, CT scan of the lumbar spine on X revealed X. Treatment to date included X. Per adverse determination dated X by X, MD, the request for X was non-certified. Rationale: "ODG by MCG Low Back (Updated: X) X for Low Back Conditions Conditionally Recommended only as an end-stage treatment alternative in selected cases of chronic intractable pain. ODG by MCG Pain (Updated:X) X for Pain Conditionally Recommended only as an end-stage treatment alternative for selected patients for specific conditions indicated in the blue criteria below, after failure of at X. ODG Criteria Indications for X: X are considered medically necessary when used to deliver drugs for the treatment of:X, are considered medically necessary when: Used for the treatment of X. A temporary trial of X is considered medically necessary only when criteria 1-4 above are met. Used for the treatment of X. (9) For average hospital LOS if criteria are met, see Hospital Length of Stay (LOS) for Pain (LOS). If treatment is determined to be medically necessary, as with all other treatment modalities, the efficacy and continued need for this intervention and refills should be periodically reassessed and documented. ODG by MCG Pain (Updated:X) X Recommended for use after there is evidence of failure of a trial of X. ODG by MCG does not address X. Peer-Reviewed Literature Cited:X. Tims far, 351 reports from around the world have been received by X. related to occurrence of pocket fill, including X events. X has been previously described, but did not result in wide acceptance in routine practice due

to cumbersome and unreliable setup. This study outlines the methodology of X. Design: Preclinical feasibility study. Setting:X: Using X were replicated. Sonographic images of those conditions were studied and an ultrasound-guided technique for accessing the X was developed. The ability to correctly X was evaluated. Outcome measurements: Positive and negative predictive value of X. Results: Both positive and negative predictive values reached 100%. Mastering the technique easy and uneventful. X has a distinctive sonographic appearance. Conclusions: X is a feasible and simple technique that may improve maintenance, routine device care, and prevent serious complications related to X. Clinical validation will be necessary in the future. The patient was diagnosed with other intervertebral disc degeneration of the lumbar region. Efficacy from X is not identified. The patient is noted to have X. Hence, the requested X is denied. “Per the Appeal Determination Denial review by X, MD on X, the request for X was non-certified. Rationale: “Per the ODG by MCG, X is recommended for use after there is evidence of X. In this case, there is no documentation that the claimant is intolerant of or X. Furthermore, there is no documented relief from previous use of this medication. “Based on the submitted medical records, the requested X is not medically supported as there is no documentation that the patient has X. No new information has been provided which would overturn the previous denials. 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:

Based on the submitted medical records, the requested X is not medically supported as there is no documentation that the patient has X. No new information has been provided which would overturn the previous denials. 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