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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 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. On X, X was X. The diagnoses were chronic back pain syndrome with lumbar disc disruption with herniated disc at L5-S1 and persistent left lumbar radiculopathy following work injury, status post successful surgery at L4-L5 and myofascial pain syndrome of the lumbar spine.

On X, X was seen by X, DO, for initial pain evaluation. X presented with the chief complaint of chronic persistent back, bilateral buttock, and leg pain below the level of the knee associated with numbness, weakness, and tingling all following a work injury on X. X reported a good longstanding work history working on X. Since that time, X had back pain, despite X. This included X. MRI of the lumbar spine on X, did show a X. X did have a remote history with X. Additionally, there was a X. At the time, X presented for consideration of X. X described X pain as continuous and sharp in nature. It was affecting X mood. X Center for X showed X. X risk for X. X X. X spot urinalysis was X. X PMP was checked to X. At the time, X graded X back pain is X. X neck pain was X, aggravated with most routine daily activities. X admitted to weight gain, sleep loss and mood irritability. Physical examination revealed X weight was 300-pounds. X walked with an antalgic limp and gait. The neuromusculoskeletal examination revealed X. X had marked X. X was elicited. X did have X. Interspinous tenderness at X was noted. Lumbosacral flexion was at X. X were noted in the lumbar spine. Treatment plan included X. X would require X was noted. Continued X was advised. On X, X was evaluated by Dr. X for a follow-up visit. X continued with moderate-to-severe back, left buttock and left leg pain, moderate lumbar interspinous tenderness. X had weakness in the X once again that day. X had X. X had a positive straight leg raising test X degrees on the left. X was citing anxiety associated with the chronicity of this pain complaint. Unfortunately, X did not do well with X. X would prefer to go back on X. They did discuss interventional pain care and X was eager to go forth with this therapy in the near future. Due to X ASA status, large body habitus, X would require minimal sedation in the prone position and they would arrange for this pending insurance authorization. On X, X was evaluated by Dr. X, for a follow-up visit. Dr. X noted X

was quite anxious. X was upset. X did not understand why reasonably necessary treatment under the ODG guidelines was not being provided. X pain had not gone away. X had an X. They were having to raise X. X was still not sleeping. They had recommended X. Additionally, X gave a long, strong history of psychiatric and emotional factors as X related to X family history. X Center for X. The doctor who denied X care did not do reasonable peer analysis or do their due diligence. X X was a time proven X this looked at factors as it related to injury and pain and was X, that was moderate reactive depression. Therefore, X was recommended. Without it, X would surely go through the X, but X likelihood of movement, anxiety, and stress during the procedure would certainly raise the morbidity rate which may include a postdural puncture headache, neural injury, numbness, weakness, worsening pain. At the time, X already had intervertebral spasm in the lumbar spine as evidenced at the time that day, that they would expect to only worsen with the XC. The anesthesia provision was minimal at best. They often used a combination of X. The national average was anywhere from X. Dr X work as studied over the last X years was X or X in a X. That being said, X wanted to have X X regardless and would arrange for this in the near future. They would submit for X as described above. Dr. X also stated that if the insurer would elect not to provide that X. X spent extra time going over this denial of care.

An MRI of the lumbar spine dated X revealed that at the X. A broad 1X was appreciated with X. At the X was present with X. At the X was noted. There was X. There was X present. There was X present.

Treatment to date included X.

Per a utilization review adverse determination letter dated X and peer review report dated X by X, MD, the request for X was denied. Rationale: “The injured worker was diagnosed with lower back pain unspecified. Although the request states that the requested X. care. There is X. Consequently, the request is denied. As such, the request for X non-certified.”

Per a reconsideration review adverse determination letter dated X and peer review report dated X by X, MD, the request for X was denied. Rationale: “Although X. Although X is proposed, the requested X. The request is not shown to be medically necessary. Therefore, the request for X is non-certified.”

Thoroughly reviewed provided records including provider notes, imaging results, and peer reviews.

Provider has necessary documentation to warrant requested X. However, the request for X is not warranted, given no extenuating circumstances noted to warrant X. Provider’s reasoning for X. X medically necessary and certified and X 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 provider notes, imaging results, and peer reviews.

Provider has necessary documentation to warrant requested X. However, the request for X is not warranted, given no extenuating circumstances noted to warrant X. Provider’s reasoning for X. X medically necessary and certified and Minimal intravenous sedation not medically necessary and non-certified.
Partially Overturned

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE