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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

Pure Resolutions LLC

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X was working as a X. The diagnosis included radiculopathy of cervical region, radiculopathy of lumbar region, low back pain, causalgia of right lower limb, intervertebral disc disorders with radiculopathy of lumbar region, neck pain, chronic pain syndrome, causalgia of left lower limb, long term (current) use of opiate analgesic, other cervical disc displacement of unspecified cervical region and wound.

On X, X was seen by X, MD for X. Since previous visit, it had become worse. The pattern of condition was persistent. Symptom was active. Severity of condition was moderate. X returned for follow up and reported that X wound care was coming to home as well as “HHPT.” X was on X and they said X would be forever. There were no changes except increased pain. It occurred in recurrent course. It was relieved by medication. Pain was described as stabbing, throbbing, sharp and dull / aching. Examination of the cervical spine showed X. X was noted over dorsal aspect of right greater than left hand. Deep tendon reflexes were diminished bilaterally. Skin showed blue-gray discoloration; moisture / temperature was warm; texture was atrophic, crusty and scaly. Fluid filled and red scaling lesion was noted. Skin of both legs and feet was swollen, erythematous and mottled legs wrapped that day. Dressing was

clean. X imaging was reviewed which included lumbar spine MRI dated X showing X. Cervical spine MRI dated X showed X. Thoracic MRI dated X showed X. Multilevel X was noted. X was recommended to continue conservative care. The leg dressings looked good that day. X was seeing wound care regularly and was antibiotic for recent infection. X was X and recent assessment showed that according to X ATP, X ongoing chair was falling apart. A recommendation was made to X as it was non-functional at the time and X stated X could not even go to the restroom. Recommendation was made for X. Dr. X felt that it was reasonable as X was unable to self-propel due to chronic neck pain and shoulder issues and generalized lack of upper extremity strength. New X were ordered.

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: “In this case, the injured worker was diagnosed with causalgia of the left lower limb. Within the records provided for review, there is no provided medical justification for requesting X. Moreover, there is no evaluation of X for the injured worker, what is wrong with it, and why it needs to be replaced. Therefore, the request for X is non-certified.” The request for X was denied. Rationale: “In this case, the injured worker was diagnosed with causalgia of the left lower limb. Within the records provided for review, there is no provided medical justification for requesting X. Moreover, there is no evaluation of the most appropriate X for the injured worker, what is wrong with it, and why it needs to be replaced. Therefore, the request for X is non-certified.”

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Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was certified. Rationale: “In this case, the injured worker is unable to X. The current X is not working and cannot be repaired. The request is medically necessary and appropriate. Therefore, the appeal request for X is certified.” The request for purchase was appropriate. The request for X was denied. Rationale: “An X is certified above. There is no documented need for a X. X can be used both indoors and outdoors. The request is not shown to be medically necessary. Therefore, the appeal request for X is non-certified.”

Thoroughly reviewed provided records including provider notes and peer reviews.

Provider’s rationale for X. The provider does not explain why the patient needs X. The provider also does not explain why the patient needs X requested. 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 provider notes and peer reviews.

Provider’s rationale for power chair does not adequately explain why patient needs X. The provider does not explain why the patient needs X. The provider also does not explain why the patient needs X components requested. X is not medically necessary and non-certified.

Upheld

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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

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☐ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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