P-IRO Inc

Notice of Independent Review Decision

P-IRO Inc.
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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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured on X. X stated X was X. The diagnosis was lumbar radiculopathy, displacement of lumbar intervertebral disc without myelopathy, and annular tear of lumbar disc.

On X, X was evaluated by X, MD, for low back pain. X presented to the office that day for follow-up after X were performed. Overall, X described an improvement of symptoms relative to X last office evaluation. Neurological examination revealed X. There was X. The assessment was lumbar radiculopathy, displacement of lumbar intervertebral disc without myelopathy, and annular tear of lumbar disc. Dr. X noted that X reported X relief in regards to X lower back pain after the X. X continued to have pain radiating down bilateral legs to the feet with numbness and tingling. X had exhausted X. X was in and would X.

An MRI of the lumbar spine dated X, identified X. X showed X. There was X. X showed X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “The Official Disability Guidelines recommend an X. The use of X is recommended. The

supported modes of X. There should be no bleeding clotting disorder or local or systemic infection. The use of X is not recommended. In Review X the request for X has been modified to certification of X on X due to the claimant presented with a chief complaint of low back pain. They had radicular pain X. Upon examination of the lumbar spine, they had decreased sensation of the knee and medial leg (X) and radicular pain along bilateral X. The cited guideline requires them to have persisting signs and symptoms of lumbar radiculopathy with supportive imaging correlating with symptoms, despite the exhaustion of conservative measures, prior to undergoing the procedure. The other above-noted criteria should be satisfied. In this case, although they have lingering lower back pain and pain radiation to both legs with numbness and tingling, following exhaustion of extensive medical measures in the past, the request for an X is not warranted, as imaging showed X. In addition, their reflexes, muscle strength, and sensation at X distribution are normal, which are not supportive of lumbar radiculopathy. Moreover, the use of X is not indicated unless exceptional factors are discussed. Therefore, the prospective request for X is non-certified."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "The prior non-certification in review X was based on the fact that the imaging showed the X. In addition, their reflexes, muscle strength, and sensation at X distribution were normal, which did not support lumbar radiculopathy. Moreover, X was not indicated unless exceptional factors were discussed. The provider is appealing the prior determination at this time without additional medicals. Based on the submitted document, the claimant sustained an injury X. The work status was undisclosed. They were diagnosed with lumbar radiculopathy and other intervertebral disc

displacement and degeneration of the lumbar region. Prior treatments were X. A lumbar spine MRI dated X showed X. There was X. Per the progress report by X, M.D., dated X, the claimant continued to have low back pain with pain radiating to the bilateral leg with associated numbness and tingling. A physical examination of the lumbar spine showed a normal range of motion, reflexes, and muscle strength in the lower extremities. There was decreased sensation of the knee and medial leg at X. There was radicular pain along X. The review of systems was positive for morning joint stiffness greater than X minutes. The provider is appealing the prior determination at this time. The Official Disability Guidelines recommend an X. The use of X guidance is recommended. The supported modes of X. There should be no bleeding clotting disorder or local or systemic infection. The use of X is not recommended. Upon review of the submitted records, it appears that the prior non-certification was appropriate. Upon examination of the lumbar spine, they had decreased sensation of the knee and medial leg (X) and radicular pain along bilateral X. The cited guideline requires them to have persisting signs and symptoms of lumbar radiculopathy with supportive imaging correlating with symptoms, despite the exhaustion of conservative measures, before undergoing the procedure. The other above-noted criteria should be satisfied. In this case, although they have lingering lower back pain and pain radiation to both legs with numbness and tingling, following exhaustion of extensive medical measures in the past, the request for an X is not warranted, as imaging showed absence of X. In addition, their reflexes, muscle strength, and sensation at **X**. Moreover, X care is not indicated unless exceptional factors are discussed. Therefore, the appeal request for X is non-certified."

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

Provider is documenting that patient had lateral recess stenosis encroaching on bilateral X. The patient did have prior successful X. Given return of pain and now in more X, request for X is warranted. However, no extenuating circumstances documented for use of X. X is medically necessary and certified. 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, imaging results, and peer reviews.

Provider is documenting that patient had lateral recess stenosis encroaching on X. The patient did have prior successful X. Given return of pain and now in more X is warranted. However, no extenuating circumstances documented for use of X. X is medically necessary and certified. X is 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