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Notice of Independent Review Decision

Sent to the Following

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured at work on X. X injured X severely at work in X. The mechanism of injury was not available in the provided medical records. The diagnoses were post-lumbar laminectomy pain syndrome with recurrent severe left lumbar radiculopathy following work injury and failed previous back surgery, neuropathic pain, and myofascial pain syndrome.

On X, X was seen by X, DO, for initial pain evaluation and treatment. X presented with chief complaint of chronic persistent severe axial back, left buttock, and left leg pain, associated with numbness, weakness and tingling following a work injury dating X. X had a good work history when X injured X severely at work in X. Since this time, X had persistent back pain with multiple levels of disc disruption and herniation most notably at X, for which X ultimately underwent X. Unfortunately, X pain continued to be moderate-to-severe in grade; numbness, tingling, sensitivity to touch were all admitted. X had poor proprioception as X was often falling. X was concerned about X future as it was affecting X quality of life, and X did admit to over 15 pounds of weight gain. X wanted to get back to earning a good wage for X family as X had been off work for almost X years. X admitted to weight gain and difficulty in walking. X did admit to ongoing mild reactive depression associated with this injury. X CESD, however was X. X risk for opioid misuse was zero. X GAD-X was X. X PMP was checked and found to be satisfactory including combination of narcotic analgesics and neuropathic pain medicines in the form of X. At the time, X rated the pain X. On examination, X was seen with some walked with an antalgic limp and gait. Head was normocephalic and atraumatic. The neuromusculoskeletal examination revealed X. X had a positive straight leg raising sign on the left at X degrees, and X had a contralateral X degrees on the right. Lumbosacral flexion was limited to X degrees with reproduction of back pain. X had interspinous tenderness at the X. Moderate sciatic notch tenderness was noted. X had decreased pinprick in the X distribution with some X noted. X was noted throughout the left lower extremity. On X, X was seen by Dr. X for a follow-up visit. Dr. X noted X continued to do well under their care. Dr. recommended a X. x was reporting sexual dysfunction following x. X was also treated for X. X was also taking X. X had been able to get off X. Dr. X opined that X should go a long way in further hastening X recovery and would send X to a

neurologist Dr. X to evaluate sexual dysfunction as well as continued neurological dysfunction including numbness, tingling, and weakness in X lower extremities following previous back surgery. Daily walking, exercise therapy, and vitamin D supplementation was encouraged. On X, X was seen by Dr. X for a follow-up visit. X presented for further care regarding X chronic back, buttock, and leg pain complaints associated with herniated disc and lumbar radiculopathy. X had positive straight leg raising sign on the left, and radiating pain below the level of the knee. Over X months ago, X got excellent relief utilizing X. X was more functional and more active. X stated X “camino mucho mejor." X walked much better. At the time, X was requiring increased use of medication management in the form of X. X did have X on an as-needed basis. The X. However, they were trying to abate this pain complaint with lower levels of care including X, which was helpful in the past. This delay in care was only increasing pain suffering, increased paravertebral spasm, which was noted that day as well as delaying X recovery. Further delay, would only lead to refractory and costly pain complaint. As a result, X would be resubmitted. Regarding this peer review denial, Dr. X stated that basically it was just throwing back information without any processing of the notations as well as X former treatments, failures, surgical intervention and at the time, relief gained through X. Due to X ASA III status, fear and anxiety was associated with X, X would require, as previously, X.
An MRI of the lumbar spine dated X, demonstrated at the X, there was a X present. At the X, there was a X. At the X present. At the X present. At the X, X was status post X. There was a X. There was X present. Regarding X, the degree of disc height loss was moderate. The degree of disc desiccation at X was moderate. Updated imaging studies were not available.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “The guidelines conditionally recommend X as a first line or second line treatment option for radicular pain with a duration of greater than X weeks when there is diagnostic Imaging that correlates with symptoms and there is a failure of greater than X weeks of conservative care including X. Repeat X are recommended when there is documentation of sustained improvement of pain or function of X, as measured from baseline, for X week after X. In this case, the individual has a history of X. Per medical reports

review, the individual received X. However, there is no documentation of the functional or objective benefit from this X and there has been no physical examination documented since X. Per previous utilization review, the individual previously received X on X with improvement in radicular pain. However, it is unclear the duration of improvement or documented functional improvement from this X Guidelines note repeat X are recommended when there is documentation of sustained improvement or functional X. As such, the request is not medically necessary or appropriate and is denied.

A letter of appeal adverse determination dated X by X, MD, was documented. However, this poorly scanned document was largely illegible.

Per a reconsideration review adverse determination letter dated X, by X, MD, the request for X was denied. Rationale: "ODG by MCG, Evidence-Based Medical Treatment Guidelines, recommend epidural corticosteroid injections selectively given all criteria is met including radicular pain lasting longer than X weeks given objective findings including diagnostic imaging supports the request and generally given failed conservative management. Per this appeal review, the provided records do not clearly document the extent of the prior conservative treatment. Additionally, it is unclear as to the objective outcome with the X. Furthermore, the prior review noted that the individual was at MMI and X was recommended. Given these factors, the request is not medically necessary nor appropriate and is denied."

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient with chronic pain issues but unclear if having acute exacerbation of pain to warrant potential X. The patient had recent similar X on X, but it is unclear based on documentation provided if this injection was successful (per cited guidelines would expect at least X pain relief for at least X weeks). The request for X is not warranted at the time. 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.

Patient with chronic pain issues but unclear if having acute exacerbation of pain to warrant X. The patient had recent X on X, but it is unclear based on documentation provided if this injection was successful (per cited guidelines would expect at least X pain relief for at least X weeks). The request for X is not warranted at the time. X is not medically necessary and non-certified

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)**