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Notice of Independent Review Decision

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: Anesthesiology

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was injured at work due to a X. The assessment was X. On X, X, MD evaluated X for Workers' Compensation involving X. After the injury, X had been evaluated by Dr. X and had been treated with X. X had right shoulder replacement in X. The right thigh, right glenohumeral, X disc, left distal tibiofibular, right knee, X disc, left thigh, X disc,

and right ankle pain was constant. The pain was described as aching, burning, constant, pins and needle-like, radiating, sharp, stabbing, tender to touch, and worsening and associated with ankle pain, back pain, foot pain, hip pain, leg pain, leg stiffness, neck pain, and shoulder pain. The pain was X at the time. All movements made the symptoms worse and nothing made symptoms better. X Reviewed Oswestry Disability Index (ODI) score was X and X disability status was bed-bound or exaggerated symptoms. The pain was described as being present across the entire lower back, both buttocks, both groins, and the entirety of bilateral lower extremity (BLE). The pain on the top of the feet was particularly severe, described as a shooting sensation that felt like they were on fire, especially when driving. The pain had been present since X but had been increasing in intensity. It was initially manageable but had become progressively worse. The pain was severe enough to require hospitalization in X due to its intensity and associated complaints of X. The pain was exacerbated by walking, driving, and certain movements such as bending or twisting. It was minimally relieved by taking X. Previous treatments had included X. A "X" at both sides of X low back X. The pain had significantly impacted daily activities. X reported being unable to put on socks, cook, walk around a supermarket, or do laundry. X reported depression and a diagnosis of post-traumatic stress disorder, with social isolation and lack of engagement with others. Associated symptoms included X, which began after X. This manifested as stress incontinence with coughing and sneezing. There was also a report of X. When this happens, there is no sensation of needing to urinate otherwise, and no urge incontinence. To manage this, X avoided fluid intake during the day and staying at home. Bowel function was normal with no fecal incontinence. On examination, X weight was 270 pounds and body mass index (BMI) of 43.6 kg/m2. X was sitting upright. Lumbar spine revealed X. Dr. X was unable to identify any specific point at / about the low back which was more tender than others. X were deferred. Lumbar spine had normal alignment, no deformity, no warmth and no masses, normal muscle tone and strength bilaterally hip, quadriceps, hamstring, tibialis anterior, extensor hallucis longus, and plantar flexion. Right lower extremity dermatomal sensation indicated “feels like a feather” to touch across the entirety of the right lower extremity. Patellar and Achilles reflexes were X bilaterally. An MRI of lumbar spine dated X revealed X. There was a X. There was X. There was a X. An MRI of lumbar spine with and without contrast dated X revealed X. Treatment to date consisted of X. Per a utilization review / adverse determination notice dated X, the request

for X was denied by X, DO. Rationale: “The Official Disability Guidelines state that an X. This procedure is indicated when there is X. In this case, the claimant presented with chronic low back pain and pain to the bilateral lower extremities. The exam showed X. MRI revealed X. They reported that the pain was minimally relieved by X. Previous treatments also included X. The provider recommended a X. While the claimant demonstrated signs and symptoms of lumbar radiculopathy, MRI indicating X, and symptoms persisted despite oral medications, the available history does not show that the claimant also tried and X. As such, the request for X is non-certified. ”Per a reconsideration review / adverse determination after reconsideration notice dated X, the appeal request for X was denied by X, MD. Rationale: “The Official Disability Guidelines state that an X. This procedure is indicated when there is X. The request for X was previously denied as the available history does not show that the claimant also tried and X. In this case, the claimant presents with signs and symptoms of lumbar radiculopathy. Sensation and reflexes were X. MRI revealed X. They are currently managing their pain medications. However, there is still no evidence that the claimant participated and has X. Based on this, the request remains unsupported. As such, the request for X is non-certified.”

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

In this case, based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. There is insufficient information to support a change in determination. The Official Disability Guidelines note that an X. This procedure is indicated when there is X. There is no supporting documentation submitted for review. There is X. There is X. There are X. Therefore, medical necessity for X is not established in accordance with current evidence-based guidelines and the determination is upheld.

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**
- ☒ **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)**