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Notice of Independent Review Decision

Amendment X

Amendment X

REVIEWER REPORT

Date: X; Amendment 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: 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. The biomechanics of the injury was not available in the provided records. The diagnosis was strain of muscle, fascia and tendon of lower back. X was seen by X, MD on X for re-evaluation with respect to a work-related injury sustained while working for X on X. X was having X pain after the medial branch blocks on the left, much better. The treatment was helping, made worse by bending and sitting too long. X had received multiple sessions of therapy which helped. X had taken medication in the past. Examination showed weight was 198 pounds. There was significantly decreased pain in the lumbar facet. X was able to stand longer, sleep longer, walk longer and decrease medication. X to follow was recommended. On X, X was seen by Dr. X for re-evaluation with respect to a work-related injury sustained while working for X on X. X felt about the same. X rated X pain X. X was able to do X regular duties, rare pain. X had not had any new symptoms. X was following the treatment plan which was helping X. X approval was pending. X had multiple sessions of physical therapy. X also stated that massage therapy helped X significantly. Examination showed flexion, extension, rotation of lumbosacral spine decreased by X. They were waiting for approval of the X. Also, X would require more massage therapy. On X, X was seen by Dr. X for re-evaluation with respect to a work-related injury sustained while working for X on X. X was having very low pain rarely and was made worse by standing. No new symptoms were noted. X was following the treatment plan. The treatment had been helping X. Examination showed flexion, extension and rotation of the lumbosacral spine was normal. X had been denied. Due to lack of improvement with conservative treatment, Dr. X opined that X would benefit from X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: “Documentation states the individual recently underwent a X that brought the individual’s pain score to a X out of X and a X at these levels has been requested. However, it is noted that a prior utilization review from X just approved a X making this requested treatment

futile and no longer indicated. As such, the medical necessity of the request is not established. “Per a utilization review adverse determination letter dated X by X, the request for X was denied. Rationale: “Per ODG "X" the claimant presented with low back pain. The request is for X. The latest office visit note reviewed does not have any signs and symptoms of facet mediated pain. Hence, request for X, is denied and noncertifiedThe requested X is not medically necessary. The submitted medical records demonstrates minimal pain. Furthermore, there does not appear to be any functional limitations as relates to pain. An examination has not been provided which would demonstrate the presence of facet mediated pain. No new information has been provided which would overturn the prior denials. 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:

The requested X is not medically necessary. The submitted medical records demonstrates minimal pain. Furthermore, there does not appear to be any functional limitations as relates to pain. An examination has not been provided which would demonstrate the presence of facet mediated pain. No new information has been provided which would overturn the prior denials. X is not medically necessary and non certified

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

☐ 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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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

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

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL