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Notice of Independent Review Decision
Amendment X

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: 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

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was X. The diagnosis was sprain of ligaments of lumbar spine. On X, X was evaluated by X, MD for low back pain. The pain radiated into the left lower extremity. An MRI of lumbar spine was X. X was able to sit and stand for X minutes, and able to walk for less than X minutes. The pain level was X at the time, X at the best, and X at the worst. The pain was felt like throbbing and aching. X had no significant changes since the last visit and no improvement in pain after the X. On examination, X blood pressure was 179/114 mmHg. Lumbar spine examination revealed X had good toe walking and heel walking. X had facet pain on the spine in rotation / extension / flexion / and palpation and axial loading. There was pain in the X. X was recommended. Also surgical evaluation was recommended. On X, X presented to Dr. X for a follow-up on low back pain. X symptoms remained unchanged. The pain level at the time was X, pain level at best was X, and pain level at worse was X. The pain was described as throbbing and aching. X helped the pain. X were denied. There was no significant change in the physical examination since last visit. An MRI of lumbar spine dated X revealed X. There X. There was no other X. The remainder of the lumbar spine was X. There was X. There was X. Treatment to date included medications (X. Per a peer review dated X by X, DO, the request for X was not medically necessary. Rationale for X: “There was documentation of the claimant having low back pain that radiated to the left lower extremity and MRI positive for X. There was also documentation that massages reportedly helped, but mention of no significant changes since the last visit and no improvement in pain after a X. Physical exam revealed X. The listed diagnosis included sprain of ligaments of lumbar spine. The treatment plan included X. However, with documentation of radiating pain in the left lower extremity and a X, this indicates a radicular component and

radiculopathy is a contraindication for X based on the guideline criteria Therefore, X is not medically necessary." Rationale for X: "The requested X is not supported; therefore, this request is not applicable." Rationale For Surgical Evaluation Referral: "X is not medically necessary. There was no documentation detailing why a surgical evaluation is being requested and how this would be helpful. Therefore, X is not medically necessary. "Per a utilization review adverse determination letter dated X, the request for X not medically certified by physician advisor. Rationale: "This correspondence pertains to the review of the following health care service(s). After peer review of the medical information presented and/or discussion with a contracted Physician Advisor and the medical provider, it has been determined that the health care service(s) requested does not meet established standards of medical necessity. This review applies only to the specific service(s) listed below. Any additional service(s) will require a separate review process. "Per a peer review dated X by X, MD, the request for X was not medically necessary. Rationale: "There is no report regarding type and extent of past conservative treatment, including formalized therapy, and its functional outcome. The request is not supported by guideline criteria. Therefore, the request for X is not medically necessary. "Per a utilization review adverse determination letter dated X, an appeal request for X was upheld not medically certified by physician advisor. Rationale: "This correspondence pertains to the review of the following health care service(s). As requested, a second contracted physician who was not involved in the original non-certification has reviewed the original information, supplemented by additional medical records submitted and/or peer discussion(s) with the treating provider. The second physician has upheld our original non-certification. "Thoroughly reviewed provided records. Patient has had extensive treatment for X. However, as an initial review X with Dr. X determined - based on ODG criteria, patient does not meet criteria for X as appears to have documented radiating pain symptoms more consistent with radicular

pain. Patient even had X prior for this pain and no significant changes noted in documentation as to why patient would now have more X. Requested procedure is not indicated. X not medically certified by physician advisor (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. Patient has had extensive treatment for back pain issues including X. However, as an initial review X with Dr. X determined - based on ODG criteria, patient does not meet criteria for X as appears to have documented radiating pain symptoms more consistent with radicular pain. Patient even had X prior for this pain and no significant changes noted in documentation as to why patient would now have more X. Requested procedure is not indicated. X not medically certified by physician advisor (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**
- ☒ **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)**