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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 worked for X and X reported that an injury occurred while X was X. The diagnoses were other intervertebral disc degeneration of lumbar region, left side sciatica and other spondylosis with radiculopathy of lumbar region. On X, X was evaluated by X, DO for X ongoing complaints of chronic low back pain. X reported pain level was X. The pain was sharp, achy and tight in nature. The pain radiated to left side to pelvic, hip, leg and foot. X reported that for about X months prior, the pain started back. X had went to the emergency room (ER) several times. X stated that the pain started on the left side of the lumbar spine and all the way down the left leg. X started to feel like someone was putting a lot of pressure on X nerves. The pain had caused X to have flare ups of restless legs syndrome (RLS) as well. X did have pain with walking, sitting, standing, bending, and twisting. X stated that X used to be very active and at the time, X was unable to do much. X always did to lean forward when sitting, walking, and standing, stating that X was weak in left leg. Examination of the lumbar spine revealed X on the left. There was altered sensation at left X. X MRI showed X. On assessment, Dr. X stated that X was on a pain pump. X reported new onset of left lower extremity radiculopathy, which was worsening over the last few months. X had previous X. X then had hardware removal. X reported X had no improvement since that time. X reported X continued to be limited. X continued to use pain pump refills monthly. X reported however this pain on left leg was new and worsening and had difficulty in standing or walking and getting around. At the time, Dr. X recommended to proceed with X. An MRI of the lumbar spine dated X revealed at X. There was X. There was right X. There was X. There was X. There was X. X of the X. There was X. There was X. There was X. There was X. At X, there was X. There was X. There was X. At X, there was X. There was X. There was X. X narrowed the right X. At X, there was X. Treatment to date included X. Per a Peer Review Report dated X, X, MD non-authorized the request for X. Rationale: “The MRI shows X. The ODG requires imaging findings that correlate with exam findings prior to surgery. Therefore, this is non-authorized. “Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “The MRI shows X. The ODG requires imaging findings that correlate with exam findings prior to surgery,

Therefore this is non-authorized. “On X, the certified utilization review agent on behalf of X, had received a request for reconsideration (appeal) regarding X, of an adverse utilization review determination related to X. Per a reconsideration / utilization review adverse determination letter and peer review report dated X by X, MD, the request for X was denied. Rationale: “The requested X is not medically necessary. The medical records do not clearly demonstrate the dermatomal distribution of symptoms that correlate with the imaging findings. In addition, it is not clear if the injured worker has exhausted, all conservative measures. As such the guidelines have not been met. The appeal request for X is non-certified. “In review of the claimant’s imaging, there was X noted to the right at X. There was X noted. The current physical exam noted X. Given these issues which do not meet guideline recommendations, it is this reviewer’s opinion that medical necessity is not established and the prior denials are upheld. 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:

In review of the claimant’s imaging, there was X noted to the right at X. There was X noted. The current physical exam noted X. Given these issues which do not meet guideline recommendations, it is this reviewer’s opinion that medical necessity is not established and the prior denials are upheld. 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)**