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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 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. X reported that while at work X received a X. X reported being unable to stand, walk, or lift without significant pain in lumbar spine. The diagnosis was sprain of ligaments of lumbar spine, strain of muscle, fascia and tendon of lower back; intervertebral disc disorders with radiculopathy of lumbar region, low back pain, lumbar intervertebral disc displacement, lumbar facet dysfunction, muscle spasm of back and lumbar disc displacement without myelopathy. On X, X was seen by X, NP /X, MD for a follow-up visit for low back pain. X had an MRI which demonstrated X. X did X for and had X. X had not improved since the date of injury (DOI). On that visit, X had pain to the lower back, rated X when walking and sitting down. X had completed X. Range of motion, radiating pain and numbness and tingling to the right leg remained the same. Lower extremity weakness remained the same to the right leg. On examination, blood pressure was 150/100 mmHg, weight was 162 pounds and body mass index (BMI) was 29.6 kg/m². Lumbar spine examination revealed X. Flexion, extension, and rotation remained the same. Muscle spasm along the paraspinal muscles and tenderness remained the same. Lower extremities examination revealed X. Muscle strength was decreased at right ankle. Bilateral straight leg raise (SLR) was positive. X-rays of the lumbar spine dated X revealed degenerative findings. X were ordered. X was still pending repeat MRI and nerve studies. X was advised to continue X as prescribed. Work status included restricted duty. On X, X was evaluated by X, MD for a follow-up visit. X reported severe progressive pain in mid lumbar,

debilitating and interfering with activities of daily living placing X at increased risk for falls. At the time, X stated that the last procedure significantly decreased X low back pain. X had X pain relief following the procedure. X was very pleased with the procedure results. However, X stated that X continued to experience low back pain. X pain had been adversely affecting X activities of daily living. X would like to continue with treatment to X low back to be able to experience prolonged pain relief and a better quality of life. The pain was characterized as sharp and aching. The pain was aggravated by standing and walking. The pain was relieved by rest. The pain was worse all the day. X rated pain X at that time of visit and X at maximum. X had undergone left X on X, X reported having 90% pain relief for two weeks after the X. X was compliant with the X as advised by the physical therapist. X was doing X. On examination, X was uncomfortable due to pain. X was in moderate distress secondary to pain. Lower back examination revealed X. There was X noted. There was marked X. X was restricted and painful in all the directions in X. X was X at X degrees bilaterally. X examination revealed X was X. Regarding X, X was able to bear weight but was painful. On assessment, X was recommended. X would continue X. X at X was recommended. X was advised to start X. Treatment to date included medications as (X), and X. Per a utilization review adverse determination letter dated X, by X, DO, the request for X was denied. Rationale: "ODG by MCG X "X for X: Physical Medicine Conditionally Recommended as indicated below. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. ODG Criteria ODG Physical Therapy Guidelines - Allow for fading of treatment frequency (from up to three or more visits per week to one or less), plus active self-directed home PT. Lumbar sprains and strains: X visits over eight weeks." In regard to requested X, as stated in the guidelines, X. ODG guidelines allow for fading treatment frequency (from up to three visits per week to

one or less), plus active, self-directed home PT. Guidelines indicate that for Lumbar sprains and strains: X visits over eight weeks is appropriate. Guidelines recommend that. In this case, the patient had X and still had pain that was rated X. On examination, there was also loss of motion, positive straight leg raises (SLR), weakness, loss of sensation, and tenderness on palpation. Although the patient has deficits on the exam and is in the subacute phase of the injury, the request is not medically necessary for this patient who had recently had X. Therefore, the requested X, is denied. "On X, Law Office of X, a reconsideration request for X was made and stated that X believed that the requested procedure was reasonable and necessary to promote healing and recovery for the compensable injury in accordance with evidence-based medicine. Per a reconsideration / utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: "I would not agree with the request. The claimant has had an adequate trial of at X. There would be no expectation that further X. There would be no medical justification at this point for X. It is reported that X is doing these. Called the physician's office and spoke with X N.P. We agreed that further X would not necessary nor expected to give benefit. "Per a Prospective Review (M2) Response dated X, "X maintains its position that the proposed treatment for X. is not medically reasonable and necessary for the treatment of the compensable injury. Reviewed documentation indicates that the claimant is a X who reported a WC injury while working as a X on X. Mechanism of injury was identified as X. Disputed conditions by the carrier includes the following: X. Significant past medical history is X. The claimant's height is 5'6" and with a weight of 170 lbs. and BMI of 29.6. As related to the injury, treatment has been X by X, MD on X, which apparently provided X pain relief. According to the Treatment Guideline, treatment of a work-related injury must be adequately documented and evaluated for effectiveness. As noted by the Physician Advisors, during the Adverse and Appeal Determination

Denials, per the ODG by MCG, the claimant has had an adequate trial of at least X. As also noted by the Physician Advisor and discussed with X, NP during a peer-to-peer conversation, there would be no expectation that X would provide any benefit over X. Further, there would be no justification at this point for X over a X. Therefore, the suggested X as requested by X, MD in a patient where the ODG criteria has not been met, is not supported and is not medically reasonable or necessary at this time. "Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review adverse determination letter dated X, by X, DO, the request for X was denied. Rationale: "ODG by MCG X. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. ODG Criteria ODG Physical Therapy Guidelines - Allow for fading of treatment frequency (from up to X. Lumbar sprains and strains: X visits over eight weeks." In regard to requested X, as stated in the guidelines, X is recommended and given frequency should be X. ODG guidelines allow for fading treatment frequency (X: X visits over eight weeks is appropriate. Guidelines recommend that X. In this case, the patient had completed X. On examination, there was also X. Although the patient has deficits on the exam and is in the subacute phase of the injury, the request is not medically necessary for this patient who had recently had X. Therefore, the requested X, is denied. "Per a reconsideration / utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: "I would not agree with the request. The claimant has had an adequate trial of at least X visits without any benefit. There would be no expectation that further X. There would be no medical justification at this point for X. It is reported that X is doing these. Called the physician's office and spoke with X N.P. We agreed that further X would not necessary nor expected to give benefit." There is insufficient

information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records document completion of X visits. Guidelines typically support an initial trial of X sessions of X to assess the patient's response to treatment and adjust the treatment plan accordingly, with up to X visits total for the patient's diagnosis with evidence of progress. The submitted clinical records fail to document any significant and sustained improvement with prior X. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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:

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review adverse determination letter dated X, by X, DO, the request for X was denied. Rationale: "ODG by MCGX. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. ODG Criteria ODG Physical Therapy Guidelines - Allow for fading of treatment frequency (from up to three or more visits per week to one or less), plus active self-directed home PT. Lumbar sprains and strains: X visits over eight weeks." In regard to requested Physical therapy, as stated in the guidelines, X. ODG guidelines allow for fading treatment frequency (from up to three visits per week to one or less), plus active, self-directed home PT. Guidelines indicate that for Lumbar sprains and strains: X visits over eight weeks is appropriate. Guidelines recommend that X. In this case, the patient had completed X. On examination, there was also loss of motion, positive straight leg raises (SLR), weakness, loss of sensation, and tenderness on palpation. Although the patient has deficits on the exam

and is in the subacute phase of the injury, the request is not medically necessary for this patient who had recently had X. Therefore, the requested X, is denied. "Per a reconsideration / utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale: "I would not agree with the request. The claimant has had an adequate trial of at least X visits without any benefit. There would be no expectation that further X. There would be no medical justification at this point for X. It is reported that X is doing these. Called the physician's office and spoke with X N.P. We agreed that further X would not necessary nor expected to give benefit." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records document completion of X. Guidelines typically support an initial trial of X sessions of X to assess the patient's response to treatment and adjust the treatment plan accordingly, with up to X visits total for the patient's diagnosis with evidence of progress. The submitted clinical records fail to document any significant and sustained improvement with X visits. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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