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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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 when X was painting a sign on the ground and hurt X back when X stood up. The diagnoses were low back pain, unspecified back pain laterality, unspecified chronicity, unspecified whether sciatica present; and annular tear of lumbar disc. Per a physical therapy discharge note dated x by X, PT /X, PT, X underwent multiple X from X through X. X reported the only time X experienced any pain was if X sat too long; however, X felt significantly less pain and stiffness overall. X reported if X sat more than an hour, pain would get to X, otherwise, pain, most of the time, was X. On examination, X standing posture was with slight extension. The lumbar spine range of motion revealed flexion was X degrees, extension X degrees, right side bending was X degrees, and left side bending was X degrees. Strength was X in flexion, extension, bilateral side bending, bilateral rotation, and lower extremities. X demonstrated improved posture, gait, and speed. Strength and flexibility was also improved in the low back and bilateral lower extremities. X was able to perform and recall all exercises with good speed and form. X was able to demonstrate excellent body mechanics with lifting, bending, and twisting. Treatment plan included discharge with X. X was seen by X, MD on X for a follow-up visit. X presented for evaluation of low back pain. X back pain developed on X while carrying a X. X had developed sudden onset lower lumbar pain. X had completed physical therapy one month prior. X back pain had improved significantly and was as rated X at the time. It was worse with standing and bending. X reported continued mild low back pain rated X. X was denied. X was taking nothing for pain. Symptoms were otherwise unchanged. On examination, X weight was 170 pounds and body mass index (BMI) was 25.85 kg/m². There was mild pain with flexion and extension in the back. X had a stable X. X-rays of the lumbar spine showed X. There was no significant instability. An MRI of the lumbar spine without contrast showed X. At X, there was X. There was X.

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current request exceeds guidelines, and it is not documented that prior therapy was efficacious, additional treatment is not supported. Therefore, the appeal request for X is non-certified. "The requested X is not medically necessary or supported by the guidelines. No information was provided which would supersede the recommended guidelines as well as overturn the previous denials. Prospective request for 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 or supported by the guidelines. No information was provided which would supersede the recommended guidelines as well as overturn the previous denials. Prospective request for 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)**