MET HEALTHCARE SOLUTIONS
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Notice of Independent Review Decision

X

IRO Case number: X

Description of the services in dispute

X

Description of the qualifications for each physician or 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:

- ☐ Upheld (Agree)
- ☒ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether **medical necessity exists** for **each** of the health care services in dispute.

Information provided to the IRO for review

X

Patient clinical history

The claimant is a X diagnosed with post-op lumbar decompression, lumbar disc herniation, strain of left groin, lumbar sprain, lumbar strain, and strain of right groin. This review is to determine if X is appropriate for the claimant's condition.

MRI lumbar spine without contrast report from X Diagnostics dated X had the following impression: X. Persistent posterior X. Severe X. Associated X. X persistent X. X are X. X persistent X. X extends into the X. Associated X. X is X. X persistent X. X extends into X. X are X.

Visit Notes from X, PA-C dated X states, "This is a X who is following up for lower back pain. X underwent a X on X to address X back pain with leg radiation pain (R>L) with tingling in the bottom of both feet. Due to persistent pain after X months post-surgery, we ordered a lumbar MRI. Since X was seen on X, X obtained the recommended lumbar MRI without contrast at X Diagnostics on X. X reports X without much noticeable improvement. X reports X X are not being approved at this time. X continues with X when able to due to pain. X continues to use the lumbar brace. X rates X low back pain X. X continues to experience pain in X right LE and the bottom of both feet, but the leg doesn't bother X that much, X is really mostly concerned about the persistent low back pain. X takes the prescribed X."

Peer Review Report from X states, "The principal reason(s) for denying these services or treatment: There are X. The clinical basis for denying these services or treatment: ODG states X is not recommended for X. A prior request was denied as there were X. The X continues to report some X. It appears that the CT myelogram is still X. There are no current findings to support X. Therefore, my recommendation is to NON-CERTIFY the request for X."

Denial Letter from X dated X states, “On behalf of the carrier/payor noted above, we decided that the services or treatments described below are not medically necessary or appropriate. This means that we do not approve of these services or treatment. This decision is the result of the appeal/reconsideration that was requested for the below treatment: X.”

Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision

The claimant is a X diagnosed with post-op lumbar decompression, lumbar disc herniation, strain of left groin, lumbar sprain, lumbar strain, and strain of right groin. This review is to determine if X is appropriate for the claimant’s condition.

X is indicated in patients who present with X. Signs and symptoms may X. The ODG guidelines state, “X. EMG (electromyography) is X. Indications for cervical EMG include patients with X. X can also be performed with X. X is not recommended for X.”

The X claimant, who previously underwent lumbar decompression at X on X, continues to experience significant lower back pain. Initially, the claimant reported X. Despite having X. X is currently managing X pain with X. Conducting an X would be beneficial for identifying X. Therefore, the denial is overturned as the requested procedure; X is medically necessary.

Description and source of the screening criteria or other clinical basis used to make the decision

☐ ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase

☐ AHRQ - Agency for Healthcare Research and 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