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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 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 at work on X. X was X. X was having pain in X back going to the buttock ever since. The diagnosis was lumbar sprain / strain. On X, X was evaluated by X, MD for the complaint of low back pain. X reported having pain ever since the injury, rated it X, and stated X was unable to work. It felt sharp and did not really radiate, but went into the buttock, but was mainly in the back. Walking, bending, standing made the pain worse and sitting made it better. X had X. X had not helped. X had an MRI that showed X. X reported X was unable to wash and dry X, work outdoors on flat ground, or sleep. X was advised to be careful lifting heavy weights. On musculoskeletal examination, flexion, extension, and rotation of the X were decreased by X in all planes. There was X. X also had palpable spasms at the X. The assessment was lumbar sprain / strain. Dr. X noted that it appeared that X did sustain an injury to the lumbar spine arising out of and caused by the industrial exposure of X. Dr. X would request X. Due to lack of improvement with X, at the time, Dr. X felt X would benefit from X. The procedure was necessary to X so that X could participate in a higher level and more meaningful rehabilitation program with the hope of returning to the former employment or continue with the ongoing employment either modified or regular work. Dr. X wrote, “X is supported by evidence-based studies, which have been summarized in the review study by X. I kindly request that the peer review physician be a board-certified specialist who is actively practicing in the field of interventional spine care. I am certain that X/X is familiar with the article by X and is well aware of the strong evidence-based data available to support my request for the above procedure. With all due respect, I do not feel that non-interventional or non-surgical physician has the adequate personal hands-on experience to deny this request. X can be downloaded via this link: X.”X-rays of the lumbar spine dated X showed X. MRI of the lumbar spine dated X revealed no significant change since X. Severe X. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the

request for X was denied. Rationale: “The request is not medically necessary. The request not supported by guidelines criteria which state – (1) X. In this case, the MRI lumbar spine reveals X. Therefore, X, is not medically necessary. “Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale: “Per Official Disability Guidelines, Low Back Chapter, Online Version, Effective Date X, Evidence-Based Medical Treatment Guidelines, Diagnostic X. A diagnostic X. No more than one X. Diagnostic X are not recommended. ODG Criteria. Criteria for Diagnostic X: Clinical presentation should be consistent with "X. X involves X." In this case, within the documentation provided for review, the patient has continued low back pain despite physical therapy. The patient has exam findings decreased X. This request was originally denied due to the MRI findings. Upon further review, there is X. Therefore, the request is not certified. Thoroughly reviewed provided records including peer reviews. Patient with continued back pain issues despite X. Patient had an MRI revealing X. The cited ODG criteria recommends against X. The second peer review also noted that there were X. However, these exam findings have limited sensitivity and specificity so are not always necessary. Given that patient continues to have regional back pain, with some exam findings, and overall presentation that could be X is warranted. X, medically necessary and certified

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Thoroughly reviewed provided records including peer reviews. Patient with continued back pain issues despite X. Patient had an MRI revealing X. The cited ODG criteria recommends against X. The second peer review also noted that there were X. However, these exam findings have limited sensitivity and specificity so are not always necessary. Given that patient continues to have regional back pain, with some exam findings, and X is warranted. X, is medically necessary and certified

Overturned

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