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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)

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 [SUMMARY]: X who was injured on X. X stated X slipped and fell at work. X landed on X buttock after twisting to avoid a ledge. X stated the pain was bilateral, radiating to bilateral hips and bilateral legs stopping at the knees. The diagnosis was sprain of ligaments of lumbar spine, initial encounter (X). On X, X was evaluated by X, MD for a follow-up visit. X reported low back pain, with pain radiated into the right lower extremity. The pain had been going on for X. The pain onset was associated with a specific event work-related injury. X fell and landed on X buttocks. An MRI of lumbar spine was positive for X. X stated that X was able to stand for less than X minutes, able to sit for less than X minutes and able to walk for less than X minutes. At the time, X rated pain X, at worst X and at best X. The pain was described as shooting, aching, burning, like a pins and needles and was constant. At the time, X was working light duty. Examination of the lumbar spine revealed X. Motor strength of right lower extremity was X. Straight leg raise was X. Sensory deficits at X was noted. The facet pain was noted on spine rotation, extension, flexion, palpation, and axial loading. The pain was present in the lumbar facets X. Plan included X. The procedure to be done X due to X degree of X. On X, X was evaluated by Dr. X for a follow-up visit for low back pain. At the time, X rated pain X, at worst X and at best X. The pain was constant, shooting and stabbing; down the right leg, also aching pain and pressure in the lower back. The pain felt better by laying down with X feet elevated. X appeal was denied. On examination, blood pressure was 145/96 mmHg. Lumbar spine examination was unchanged. An appeal was made. An MRI of

lumbar spine dated X. The lateral recesses at X were borderline to mildly narrowed X. There were X. There was X seen. An electromyography (EMG) report of the lumbar spine and bilateral lower extremities dated X revealed X. There was no evidence suggestive of X. There were findings of increased X. Treatment to date included X. Per a utilization review adverse determination letter and peer review dated X by X, MD, the request for X was denied. Rationale: “Per Official Disability Guidelines, Pain, Online Version (X), X, "Recommended as an option; may be a first-line or second-line option. ODG X may be indicated when ALL of the following are present (1) (2) (3) (4) (5) : Radicular pain, duration of >= X weeks, and X or more of the following (3) (6) : Lumbar radiculopathy by history (eg, radiation of pain and numbness along the distribution of the affected spinal root), and ALL of the following: Diagnostic imaging (eg, CT scan, MRI) correlates with symptoms. Procedure performed X approach Repeat X in patient with good response to X, as indicated by ALL of the following (12): Documentation of sustained improvement of pain or function of >= X, as measured from baseline, for >= X weeks after X Pain or deterioration in function since X Pain causes functional disability. Patient has had < X. Procedure performed X" In this case, lumbar spine MRI revealed X. Moreover, there is no record of objective functional gains after the previous X. Therefore, this is not medically necessary. Thus, this is not certified. “On X, an appeal for X was made. Per a reconsideration / utilization review adverse determination letter / peer clinical review report dated X by X, MD, the appeal request for X was denied. Rationale: “The submitted medical documentation fails to provide compelling objective information to meet the medical necessity of this request. The most recent medical progress note dated X from X, MD indicates subjective complaints of low back pain with radiation into the right lower extremity, as well as objective findings of decreased motor strength of the right lower extremity and sensory deficits right X. ODG discusses X and provides specific criteria to be met. In this case, while the submitted documentation provides evidence of sensory

deficits of the X. Additionally, MRI of the lumber spine dated X provides evidence of X as requested. There is no discussion of X. Additionally, the request was previously denied on peer review with no new additional clinical information submitted to justify reversing prior determination. Given this information medical necessity for the current request cannot be established. Therefore, based on the medical documentation provided, and using the evidence-based, peer-reviewed guidelines, recommendation is to non-certify this request. “Thoroughly reviewed provided records including peer reviews. Noted that the patient had X. On the other hand, MRI was unremarkable for corroborating findings. Thus, NCS/EMG obtained and does show findings consistent X. Given electrodiagnostic findings consistent with examination, patient’s pain could be from this pain generator. X has also X. Based on a variance of the ODG criteria cited above, requests for X are warranted. X is 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. Noted that the patient had X. On the other hand, MRI was unremarkable for corroborating findings. Thus, NCS/EMG obtained and does show findings consistent with X. Given electrodiagnostic findings consistent with examination, patient’s pain could be from this pain generator. X has X. Based on a variance of the ODG criteria cited above, requests for X are 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**
- ☒ **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)**