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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 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 sustained an injury on X. X developed low back pain after repetitive lifting. The diagnoses included lumbar radiculopathy, lumbar facet joint syndrome, lumbar intervertebral disc herniation, bilateral sacroiliitis, and low back pain. Per the prior review, X was evaluated on X. X returned complaining of low back pain with radiation down the back of the right leg as well as numbness in the right fourth and fifth toes. X pain and numbness had progressively worsened. X used X sparingly as well as X. X had difficulty bearing weight on X right leg. Examination revealed X. There was X. Strength was X in the lower extremities. Reflexes were X and equal in the lower extremities. X was X. X had pain along the right X. X was advised to X. Since X had diagnostic and X. X would follow up in X weeks. Per the prior review, A lumbar spine MRI dated X revealed at X. Treatment to date included X Per Utilization Review - Notice of Adverse Determination by X, MD on X, the requests for X were non-certified. Rationale: "The principal reason [s) for denying these services or treatment: The patient's objective examination findings correlate with MRI findings. The clinical basis for denying these services or treatment: The Official Disability Guidelines state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms of radiculopathy. The patient has been diagnosed with radiculopathy. Electrodiagnostic studies may be recommended with evidence of failure to resolve or a plateau of suspected radicular pain without resolution after conservative treatment when there are equivocal imaging findings such as CT or MRI, and suspicion by history and physical examination that a neurologic condition other than radiculopathy may be present instead of, or in addition to radiculopathy. The submitted records do not establish equivocal imaging findings, or suspicion that a neurological condition other than radiculopathy may be present instead of, or in addition to radiculopathy. There is minimal justification for performing nerve conduction Studies when a patient is presumed to have symptoms of radiculopathy. The patient's objective examination findings correlate with the MRI findings. Therefore, my recommendation is to NON-CERTIFY the request for X.The principal reason [s) for denying these services or treatment: The patient is being followed for lumbar radiculopathy. The clinical basis for denying these services or treatment: The Official Disability Guidelines state that there must be an absence

of radicular pain. The patient is being followed for lumbar radiculopathy. The Official Disability Guidelines state that there must be an absence of radicular pain. Given the patient's presentation of radiculopathy, X does not meet the criteria in the guidelines for X. Therefore, my recommendation is to NON-CERTIFY the request for X. The principal reason[s] for denying these services or treatment: According to the X report, the patient reported X improvement with the X on X. The clinical basis for denying these services or treatment: The Official Disability Guidelines state that a X. The Official Disability Guidelines state that X. According to the X report, the patient reported X on X. The records do not establish that the patient experienced at least X. X including X. Therefore, my recommendation is to NON-CERTIFY the request for X. The principal reason [s) for denying these services or treatment: The records do not establish any objective functional improvements associated with X. The clinical basis for denying these services or treatment: The Official Disability Guidelines allow for up to X. This request exceeds the recommendations in the guidelines. This request exceeds the guidelines. The records do not establish any objective functional improvements associated with X. Despite X, the patient remains unable to work. The patient is nearly X. The patient has residual complaints and there are X. Therefore, my recommendation is to NON-CERTIFY the request for X: X." Per appeal of utilization review denial - adverse determination review by X, MD on X, the requests for Appeal X; Appeal X; and Appeal X were non-certified. Rationale: "The principal reason[s) for denying these services or treatment: According to the X report, the patient reported X on X. The clinical basis for denying these services or treatment: The Official Disability Guidelines state that a X. Peer review performed on X non-certified the request for X. It was noted that according to the X report, the patient reported X on X. The records do not establish that the patient experienced at least X. The records do not include any new documentation that would overturn the prior peer review determination. Given that the patient did not obtain an adequate response to the X is not indicated. Therefore, my recommendation is to NONCERTIFY the request for X. The principal reason(s) for denying these services or treatment: The records do not establish any objective functional improvements associated with X. The clinical basis for denying these services or treatment: The Official Disability Guidelines allow for up to X. This request exceeds the recommendations in the guidelines. Peer review performed on X non-certified the request for X. It was noted that this request exceeds the guidelines. The records do not establish any objective functional improvements associated with X. Despite X, the patient

remains unable to work. The patient is nearly X. The patient has residual complaints and there are X. The records do not include any new documentation that would overturn the prior peer review determination. As previously noted, the records do not establish objective functional improvement from X. At this juncture, focus should be on a X. Therefore, my recommendation is to NON-CERTIFY the request for X; Appeal X. The principal reason [s) for denying these services or treatment: Guidelines do not support the requested injections. In addition, the patient currently has radicular symptoms in the right lower extremity with positive examination findings and corroborating imaging findings. The clinical basis for denying these services or treatment: The Official Disability Guidelines state that X are not recommended for lower back conditions due to a lack of quality supportive evidence. While X is not recommended, if still performed, guidelines state that there should be an absence of radicular pain. Peer review performed on non-certified the request for X. It was noted that the patient has radicular symptoms in the right lower extremity with positive examination findings and corroborating imaging findings. Subsequent peer review on X non-certified the request for X. It was noted that the patient is being followed for lumber radiculopathy. The Official Disability Guidelines state that there must be an absence of radicular pain. The records do not include additional documentation that would overturn the prior peer review determination. Given this patient's history of radiculopathy, X remain unsupported. Therefore, my recommendation is to NON-CERTIFY the request for X; Appeal X." The patient has clinical symptoms of a lumbar radiculopathy. Thus, the requested diagnostic test does not provide any additional benefit to the patient and is not supported by the guidelines. The requested X is not medically necessary as the patient had these X. A X is not indicated or supported by the guidelines. The requested X is not supported as the records indicate the presence of a lumbar radiculopathy. The guidelines do not support X in the presence of a lumbar radiculopathy. The requested X is not supported as the patient has had X. X is not indicated or supported. No new information has been provided which would overturn the previous denials. ITEM 1: X are not medically necessary and non certified

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

The patient has clinical symptoms of a lumbar radiculopathy. Thus, the requested

diagnostic test does not provide any additional benefit to the patient and is not supported by the guidelines. The requested X is not medically necessary as the patient had these X. A X is not indicated or supported by the guidelines. The requested X is not supported as the records indicate the presence of a lumbar radiculopathy. The guidelines do not support X in the presence of a lumbar radiculopathy. The requested X is not supported as the patient has had X. X is not indicated or supported. No new information has been provided which would overturn the previous denials. ITEM 1: X are 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)**