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Notice of Independent Review Decision
Amendment X

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Notice of Independent Review Decision

Case Number:X Date of Notice: X

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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: NO OFFICE VISITS ARE PROVIDED.X who sustained an injury on X. The biomechanics of the injury is not included in the available records. The diagnoses included radiculopathy, lumbar region; lumbago with sciatica, X side; and lumbago with sciatica X side. Per the utilization review note dated X, X was seen on X by the treating provider. X presented with X. X was status post X. Prior treatments included physical X. X of the lumbar X dated showed X. Per the utilization review note, treatment to date included X. Per the Adverse Determination review by X, MD on X, the request for X was non-certified. Rationale: "No, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Official Disability Guidelines state that X is not recommended. In this case, Imaging revealed X. However, the submitted clinical note did not contain a comprehensive physical examination. Therefore, there is a lack of physical exam findings to support that both requested levels are X. Given the above, the request for X is non-certified." Per Adverse Determination After Reconsideration review by X MD on X, the request for X was non-certified. Rationale: "No, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Official Disability Guidelines do not recommend X. On X, the claimant presented with X. X is status post X. Previous treatments included X. X of the lumbar X dated X showed X. The prior review dated X non-certified the request for X. In this case, there was still no comprehensive physical examination on the submitted medical records. Furthermore, guidelines do not recommend X. As such, the requested X remains non-certified at this time." Thoroughly reviewed provided records including provider notes and

peer reviews. Also performed extensive literature search of X. Patient with significant pain issues around X and has had X. The patient is considering further options. However, there are no findings on physical exam to support intervention at these levels. More importantly, X. While sometimes experimental therapy may be indicated after X. 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:

Patient with significant pain issues around X and has X. The patient is considering further options. However, there are no findings on physical exam to support intervention at these levels. More importantly, X. While sometimes X may be indicated after X is not medically necessary and non certified
Upheld

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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
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)