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Notice of Independent Review Decision

SENT TO: Texas Department of Insurance
Managed Care Quality Assurance Office
(MCQA) MC 103-5A Via E-mail
@tdi.texas.gov

DATE NOTICE SENT TO ALL PARTIES: 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:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X.

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a X who sustained injuries to the lower back and lumbosacral spinal cord on X. The injury occurred when the claimant was X. The claimant was diagnosed with sprain of ligaments of lumbar spine, stiffness of unspecified joint, contusion of the scalp, muscle spasm of back and low back pain.

An X of the lumbar spine w/o contrast dated X, revealed at X. No X or marked X was seen. Borderline X compared to the X. This finding was non-specific but usually secondary to a X.

According to the Initial Pain Evaluation by X, D.O., on X, there was documentation of X. The pain was currently rated as X and it was X. The back pain was worse with X. The claimant recently had a cold and the pain had gotten worse. It was worse with sitting for prolonged periods of time. The claimant felt “weak in the back” and at night often sat down and raised the legs due to intense spasms. Valsalva maneuvers

were markedly provoking. Prior treatments included conservative, physical therapy, rehabilitative care including X, X, and an MRI of the lumbar spine on X.

The physical exam of the lumbar spine revealed the claimant was in X. The assessment included the diagnosis of chronic back pain syndrome with lumbar disc protrusion X with persistent lumbar radiculopathy following work injury and secondary myofascial pain syndrome.

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

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition- Chapter: Low Back- Lumbar and Thoracic "Radiculopathy must be well-documented, along with objective neurological findings on physical examination. Acute radiculopathy must be corroborated by imaging studies and when appropriate, electrodiagnostic testing, unless documented by pain, reflex loss, and myotomal weakness abnormalities support a dermatomal radiculopathy diagnosis. A request for the procedure in a patient with chronic radiculopathy requires additional documentation of recent symptom worsening associated with deterioration of neurological state."

Per evidence-based guidelines, and the records submitted, this request is non-certified. In this case, there is no documented evidence of X lumbar spine MRI. No myotomal weakness or deep tendon reflex loss were noted on physical examination. Per ODG, "X is not generally recommended. When required for extreme anxiety, a patient should remain alert enough to reasonably converse." There is no record of extraordinary circumstances that would necessitate X for this procedure. Excessive X is not recommended and there is no record of factors that would indicate such deep X as to require involvement of an X or X. It is unclear why X is requested when only X is planned. Therefore, the request for a X is not medically necessary.

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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY 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)**