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***Notice of Independent Review Decision
Amendment***

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 is a X who was injured on X. X was X. X stated a X with X. The diagnosis included lumbar sprain /strain and spasms, lumbar facet joint and ligamentous injury at X and X, lumbar radiculitis along X distribution and right sacroiliac joint injury. On X, X was seen by X, DO / X, PA-C for lumbar back pain. Pertaining to X lumbar back pain, X reported X pain still persisted and still bothered X with X. X reported radiation of pain to X right X. X reported X pain bothered X more around X. X would like to discuss further treatment options for X lumbar back pain. X believed X had completed X. X reported X was still waiting for X for X pain. X was recommended to continue with active X. On examination of lumbar spine, X included flexion to X degrees, extension to X degrees, lateral rotation and flexion to X degrees. There was pain with X. X was noted into X more on X right side, into X processes and the X. X with pain into X right sacroiliac joint.

X was X on the right. X was recommended to continue with X. X was recommended to continue with X. X had completed X and was waiting for X. X was recommended to continue with work restrictions until further improvement and until further evaluation. X was recommended to continue X, X. On X, X presented to X/X for follow up of lumbar back pain. Pertaining to X lumbar back pain, X reported X pain still persisted and still bothered X with X. X reported radiation of pain to X right SI joint and pain into X gluteus more on X right side. X reported X pain bothered X more around X axial lumbar area. X would like to discuss further treatment options for X lumbar back pain along with right SI joint pain. X reported X completed approximately about X. X reported X Workers Compensation denied X additional X. X was recommended to continue with X provider at X for further management of X lumbar back pain and also to be referred to the designated provider for further evaluation of X injury as well. X was recommended to continue with active home core stretching, muscle strengthening exercises and aquatic exercises at home. X also reported X Workers Compensation denied X request and X denial letter recommended more X for X pain per the Workers Compensation guideline. However, the Workers Compensation denied X additional X, which contradicted the guideline recommendation. On examination of lumbar spine, lumbar range of motion included flexion to X degrees, extension to X degrees, lateral rotation and flexion

to 40 degrees. There was pain with X range of motion. Tenderness, tightness, triggering and spasm was noted into X lumbar musculature more on X right side, into X lumbar spinous processes and the facet joints more from the level of X to X, into X right PSIS and into the right sacroiliac (SI) joint area. FABER test, pelvic compression test and Yeoman test were positive with pain into X right sacroiliac joint. Straight leg raise test was positive on the right. X was recommended to continue with home exercises and aquatic exercises at home. X was recommended to continue with active home therapies including ice and heat to the affected areas, stretching, and massage three times daily as needed. X had completed approximately X and was waiting for additional X. X was recommended to continue with work restrictions until further improvement and until further evaluation. X was recommended to continue X,X, topical cream and patches. Prescription for X was given. Right sacroiliac joint injection was recommended. X Workers Compensation denied X based on the guideline without actually seeing X in the office in-person. In Dr. X opinion, it was medically necessary for X to undergo X to help with X pain further due to persistent pain. Dr. X opined that X would benefit from X to help with X pain further. An MRI of the lumbar spine dated X showed X and foraminal disk protrusion at X was present. Left foraminal narrowing was present accentuated by left facet spurring and hypertrophy. The left X nerve root could be affected. The disk was dehydrated and narrowed. Incidental 1.9 cm hemangioma in the X vertebra was present. The lumbar spine was otherwise normal. Treatment to date included medications, physical therapy, modified activity and home exercises. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The Official Disability Guidelines do not recommend X, based on insufficient evidence. On X, the claimant was seen for a follow up visit and reported low back pain with radiation to the right SI joint and right gluteus. The claimant reported the pain has affected X range of motion, activities, standing, walking, lifting, pushing and prolonged weightbearing. On examination, the lumbar spine had tenderness, tightness, triggering and spasm in the lumbar musculature more on the right side, the spinous processes, the facet joints from level X, the right PSIS and right SI joint area. The range of motion was flexion 70 degrees, extension 20 degrees, lateral rotation, and flexion 40 degrees. There was pain with range of motion. There was positive Faber's, pelvic compression, and Yeoman's test with pain in the right SI joint. Straight leg raise was positive on the right. The strength was five out of five (5/5) bilaterally. Sensation was intact to

bilateral lower extremities. Reflexes were X. The claimant completed X. Lumbar MRI dated X impression: X. X is present accentuated by X. The left X could be affected. The X is X. X is present. X is otherwise X. While there is documentation for low back pain, the guidelines do not recommend X based on insufficient evidence. Partial certification is not permitted in this jurisdiction without peer-to-peer discussion and agreement." Per an Appeal Determination Denial letter dated X by X, MD the request for X was denied. Rationale: "Per Official Disability Guidelines (ODG) "X. This is a condition that is generally considered rheumatologic in origin (classified as ankylosing spondylitis, psoriatic arthritis, reactive arthritis, arthritis associated with inflammatory bowel disease, and undifferentiated spondyloarthropathy). Instead of X for non-inflammatory sacroiliac pathology, conservative treatment is recommended. Current research is minimal in terms of trials of any sort that support the use of X for non-inflammatory pathology. Below are current reviews on the topic and articles cited. There is some evidence of success of treatment with X for inflammatory spondyloarthropathy, although most rheumatologists now utilize biologic treatments (anti-TNF and/or disease modifying antirheumatic drugs) for treatment." The patient saw the treating provider on X. The patient reports low back pain. The patient has participated in physical therapy. On examination, there is a positive Faber, pelvic compression, and Yeoman's sign on the right. There is pain radiating in the right X distribution. The requested X is not medically necessary. The guidelines do not support X. The guidelines have not been met. No new information has been provided which would overturn the previous denial. Therefore, the requested X; is denied. The ODG does not recommend X for noninflammatory sacroiliac pathology. X are recommended on a case-by-case basis for inflammatory spondyloarthropathy. In this circumstance, the injured worker reports low back pain that radiates the right SI joint and gluteus. They relate that pain is worse around the axial lumbar spine. Treatment has included physical therapy, activity modification, medications. On exam there is pain with lumbar motion, tenderness and spasming of the lumbar musculature in the right as well as the right spinous processes and facet joints X1 and right SI joint area. There is a positive FABER test, pelvic compression test, and Yeoman test. There is a positive straight leg raise on the right. An MRI documented a disc protrusion at X impinging the left X nerve. The provider has appealed a recommendation for X. While there is not documentation of inflammatory spondyloarthropathy, a deviation from the guidelines to allow for X is recommended. The injured worker

complains of pain at the right SI joint which is corroborated by examination findings consistent with sacroiliac pathology. They have failed conservative treatments included X. A trial of an X is supported to help eliminate pain and continue conservative management. Therefore, X is certified. X is medically necessary and certified

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

The ODG does not recommend X for noninflammatory sacroiliac pathology. X are recommended on a case-by-case basis for inflammatory spondyloarthropathy. In this circumstance, the injured worker reports low back pain that radiates the right SI joint and gluteus. They relate that pain is worse around the axial lumbar spine. Treatment has included physical therapy, activity modification, medications. On exam there is pain with lumbar motion, tenderness and spasming of the lumbar musculature in the right as well as the right spinous processes and facet joints X and right SI joint area. There is a positive FABER test, pelvic compression test, and Yeoman test. There is a positive straight leg raise on the right. An MRI documented a disc protrusion at X impinging the left X nerve. The provider has appealed a recommendation for X. While there is not documentation of inflammatory spondyloarthropathy, a deviation from the guidelines to allow for X is recommended. The injured worker complains of pain at the right SI joint which is corroborated by examination findings consistent with sacroiliac pathology. They have failed conservative treatments included medications and physical therapy. A trial of X is supported to help eliminate pain and continue conservative management. Therefore, X to the lower back is certified. X is medically necessary and certified

Overtured

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)**