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Notice of Independent Review Decision
Amendment

IRO REVIEWER REPORT

Date:X; Amendment X

IRO CASE #: NA

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 Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured on X. X was an X and was X. The diagnoses were spinal stenosis of lumbar region with neurogenic claudication and low back pain. On X, X was seen by X, MD for a follow-up visit to review X. X reported X. X complained of intermittent bilateral back pain which radiated to the hips, knees, legs, and feet. X was experiencing a heavy sensation to bilateral lower extremities. The pain level was 4/10. On examination, X was X. X station was X. Motor strength was X. Neuro / motor examination revealed bilateral (X) radiculopathy. X pain influenced with lumbar flexion / extension / rotation. Point tenderness was seen over (X and X) X. There was X. There was decreased X. There was decreased X. The treatment plan was to X. A CT scan of X dated X revealed status post X. There was X of X present. There was X present at X. There was X. There was X. There was X. Treatment to date included medications (X), X. Per a peer review report dated X by X, MD, the request for X was denied. Rationale: “In this case, the injured worker has X. CT formal report was not provided and is only noted to be two weeks ago. Therefore, the request for X is not medically necessary.” Per a utilization review adverse determination letter dated X by Dr. X, the request for X was denied. Rationale: “In this case, the injured worker has X. CT formal report was not provided and is only noted to be two weeks ago. Therefore, the request for X is not medically necessary. “On X, Dr. X wrote an appeal letter for reconsideration stated that X was under X care and was seen on X. X presented with constant debilitating, constant increasing back

pain. They needed to continue treatment to alleviate the pain he was reporting. X was having difficulties carrying out daily living activities, since the accident that occurred on X. They needed to obtain results of MRI of lumbar to see if there were any abnormalities or lesion that was causing the heaviness and weakness to lower extremities, and postoperative changes. X was status post lumbar surgery in X by Dr. X. X had been under medication over X with minimal relief. X had been referred to X. Per a peer review report dated X by X, MD, the request for X was denied. Rationale: "This is non-authorized. The request for X is not medically necessary. Per ODG, New neurologic symptoms. In this case, the injured worker presented with complaints of Lumbar pain. Physical examination of the lumber revealed X. However, examination does not specify new positive neurological deficits such as diminished strength or reflexes. Therefore, based on lack of evidence, medical necessity cannot be established." Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "This is non-authorized. The request for X is not medically necessary. Per ODG, New neurologic symptoms. In this case, the injured worker presented with complaints of Lumbar pain. Physical examination of the lumber revealed X. However, examination does not specify new positive neurological deficits such as diminished strength or reflexes. Therefore, based on lack of evidence, medical necessity cannot be established. The requested X is not medically necessary. A CT scan of the lumbar spine was previous obtained on X. The submitted records did not demonstrate a progressive neurological deficit. No new information has been provided which would overturn the previous denials. X between X and 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:

The requested X is not medically necessary. A CT scan of the lumbar spine was previous obtained on X. The submitted records did not demonstrate a progressive neurological deficit. No new information has been provided which would overturn the previous denials. X between X to X is 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

☐ 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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL