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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 Overturned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X fell X. X injured X . The diagnosis was lumbar sprain and strain. X was seen by X, MD on X for a follow-up. X still complained of X. The pain was rated X. X was working, which was made worse by X. No new symptoms were noted. X had X. X was awaiting approval for X. Examination of both lower extremities showed X. Flexion, extension, rotation in the lumbosacral spine had decreased by X. Motor strength was X on the left and X on the right. X was X. There was X noted on X. Per Dr.X, X had reached a point in the treatment plan where the determination was to proceed with an X. That decision was based upon the complex nature of the injury, how it was impacting the bodily function as well as the fact that X had X. X would require X. X had elected to proceed with the X. X consulted Dr. X on X for a re-evaluation. X reported feeling about the same. The pain was rated X. The pain was occasional and worsened by X. It was made better by X. X gave no indication of X. On examination, X. Flexion, extension, and rotation of lumbosacral spine was decreased by X. X was X. X were noted. There was decreased X noted. X had a follow-up with Dr. X on X for complaints of low back pain radiating to both lower extremities, right more than left. X complained of neck pain and headache as well as left upper extremity pain, rated X. Nothing made the pain better or worse. X had taken X. X had X. One week of X. On examination, X. Flexion, extension and rotation of lumbosacral spine was decreased by X. X was X in lower extremities with decreased X. X was X. X were X. X had X on palpation of the lumbar spine at X. X had X at X. Range of motion of the cervical spine was decreased by X. X had X at X. An MRI of the lumbar spine dated X demonstrated X. At the X , there was X. At the X. At the X. At the X. An x-ray of the lumbosacral spine dated X showed X. X was present, most pronounced at X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD the request for X, per X order, X , per X order, and X , per X order was

noncertified. Rationale: “Official Disability Guidelines recommends X. On X, the claimant complains of low back pain radiating to bilateral lower extremities. Examination shows X. No MRI results included for review and there is X. As such, the requests for X, per X order; X , per X order; X, per X order are non-certified. “Per a reconsideration utilization review adverse determination letter dated X by X, MD, the request for X, per X order, X , per X order, and X, per X order was noncertified. Rationale: “The Official Disability Guidelines would support X. The previous review did not certify this request due X. Subsequent progress notes dated X, also do not include a complete neurological examination. No MRI results are provided. Additionally, X is only supported for those with X and none is noted. Accordingly, the request for X is non-certified. The requested X is not medically necessary. There is no rationale for the need of X. There is no indication of X. Furthermore, the records do not reflect a X. X per X order. X per X order. X, per X order 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 requested X is not medically necessary. There is no rationale for the need X . There is no indication of X. Furthermore, the records do not reflect a X. X per X order. X, per X order. X, per X order. X, per X order 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