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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 Overtuned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who sustained an injury on X. At work, a X. The diagnoses included lumbar radiculopathy, chronic pain syndrome, muscle spasm, chronic use of opiate drug for therapeutic purpose, lumbar spondylosis, sacrococcygeal disorders, and other chronic pain. X was seen by X, MD on X X, MD for lower back pain. X stated the low back pain radiated down the right leg into the right knee and rated it X. X complained of severe pain to lower back, not able to complete X ADLs due to pain. On examination of the thoracolumbar region, X appeared to be in pain in X. There was pain to X at X. X was limited due to X. X was X on the right and negative on the left. X was within X. X were X. X was X. X was able to bear weight, but was painful. X received right X and X. X X was consistent on X with prescribed medications. X had X. On X, X presented with low back pain and right hip pain. X described X pain as a constant ache and sharp pain that radiated up to the middle of the back to the base of the neck and down the right leg down to the mid-thigh with constant numbness, tingling, and lower back burning. X rated X pain X. X reported X got X relief lasting for about X days with X on X. The pain was exacerbated by X. X requested a X. X was doing at X. On thoracolumbar spine examination, X appeared to be in X. X exhibited pain to X at X through X. X was limited due to stiffness and pain. X was X on the right and negative on left. X was able to bear weight but was painful. X X was consistent with the prescribed medications on X.In the telephone encounter note dated X , Dr. X requested a reconsideration. X considered that a right X was necessary and that it should be done as soon as possible to help X with the severe pain that was affecting X daily life and also to improve back function for more range of motion, which may allow X to continue with a X and avoid or delay surgery, which could carry additional risks and a long recovery period. X complained of low back pain. X described pain as a constant X.

X rated X pain an X. X stated the pain worsened with X. X was doing X. X had a X on X. X reported X relief for X days with reduced pain with X. Dr. X is requesting a X that would be the X because X suffered from lumbar radiculopathy and X complained of severe pain to lower back, the pain was worse day after day. Per the justification of medical necessity, X pain had been present for more than X weeks and was an X pain scale. X was not able to complete X ADLs due to pain. Conservative management included X. An MRI of the lumbar spine on X showed status X. Treatment to date included X. Per the utilization review by X, MD on X, the requests for X were non-certified. Rationale: “Radiculopathy is not well defined by physical examination, there is no recent exacerbation with neurological deterioration, and there is no documented symptom-free period, or assessment of the X. The clinical basis for denying these services or treatment: The Official Disability Guidelines require that radiculopathy be well defined with objective neurological findings on physical examination, and do not recommend X. On X the provider did not identify any sensory or motor deficits in a nerve root distribution to suggest radiculopathy. The condition is chronic, and the ODG states that a request for the procedure in a patient with chronic radiculopathy requires additional documentation of recent symptom worsening associated with deterioration of neurologic state. There are no neurological deficits reported, and no deterioration of neurological state. Additionally, it appears the provider performed a X on X despite lack of authorization and has made plans for the X at an unspecified level to be performed on X without assessment of the outcome of the X. The ODG by MCG states that each X should be evaluated with objective improvement before scheduling an X , such as improved functional ability or reduction in X requirements. The patient does not meet the ODG criteria for a X and does not meet the criteria for a X. Therefore, my recommendation is to NON-CERTIFY the request for X.” Per the utilization review by X, MD on X, the requests for X, unspecified level and

X, additional level were non-certified. Rationale: “The X physical examination findings do not support a diagnosis of right radiculopathy, as well as a recent exacerbation with neurological deterioration. The clinical basis for denying these services or treatment: The Official Disability Guidelines require that radiculopathy be well defined with objective neurological findings on physical examination and X. The patient sustained an injury in X. X condition is chronic. Per the Official Disability Guidelines, a request for the procedure in a patient with chronic radiculopathy requires additional documentation of recent symptom worsening associated with deterioration of the neurologic state. This is not evident in this case. The current medical report on X does X. The examination notes X. An X was performed on X despite non-certification. Per the X note, the patient reported X relief for X days. However, there was no indication of functional improvement or a reduction in medications. Per ODG, repeat X. For these reasons, the patient does not meet the criteria for a X. Therefore, my recommendation is to NON-CERTIFY the request for APPEAL: X.” The requested X is not medically necessary or appropriate. The patient has previously undergone X which only provided X days of relief. The patient has chronic pain. There is no indication of any acute exacerbation. Furthermore, the guidelines do not support an X. The records reflect that the X. No new information has been provided which would overturn the previous denials. ITEM 1: X are not medically necessary and are 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 or appropriate. The patient has previously undergone X which only provided X days of relief. The patient has chronic pain. There is no indication of any acute

exacerbation. Furthermore, the guidelines do not support an X. The records reflect that the X. No new information has been provided which would overturn the previous denials. ITEM 1: X are not medically necessary and are 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**

☒ **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)**