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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 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 was injured on X. X had X. The diagnosis was lumbar disc disorder and lumbago. On X, X was evaluated by X, MD for initial evaluation and treatment in regard to low back pain. X had radiating lower back pain rated X to greater than X. The pain was X. The lower back pain was X. X had failed to experience lasting relief with X. X continued X. X complained of low back pain with radiation into the left buttock and lower extremity. X low back and left buttock pain. On examination, blood pressure was 142/98 mmHg, 204 pounds and BMI 29.3 kg/m2. X was a well-developed, well-nourished X in no acute distress. X was alert and oriented X. Mood and affect were appropriate X were X throughout. X was X. X was able to perform X. X had increased left low back and left buttock pain with lumbar flexion. Motor was X throughout and sensation was grossly intact throughout. Deep tendon reflexes were X. Review of X lumbar MRI showed X. The assessment was lumbar disc disorder and lumbago. Dr. X felt that X would benefit from X. An MRI of the lumbar spine dated X demonstrated X. Treatment to date has included X. Per a utilization review / adverse determination dated X by X, MD, the request for X was denied. Rationale: “Regarding X. This treatment should be administered in conjunction with X. A request for the procedure in a patient X. The symptoms should be X. Considering this and as there is a lack of evidence of X, the medical necessity of the requested treatment is not established. Denial is recommended.” In a letter dated X, Dr. X requested an expedited appeal for X for denial of X. X had been doing a X in X by the orthopedic Dr.X. Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X was denied as not medically necessary. Rationale: “The Standard appeal

Request for X is not recommended as medically necessary. The claimant's physical examination fails to X. The submitted X. Therefore, medical necessity is not established in accordance with current evidence based guidelines. Thoroughly reviewed provided records including imaging interpretations and peer reviews. Patient with continued back pain X. Patient also may have corresponding imaging findings based on interpretation of provider. Though X are limited, the patient does not need to X. Such deficits would actually be more concerning and likely warrant more immediate surgical intervention. Requested X corresponds with patients subjective complaints and objective findings and is warranted. X is medically necessary and certified.

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

Patient with continued back pain radiating to X. Patient also may have corresponding imaging findings based on interpretation of provider. Though X are limited, the patient does not need to X. Such deficits would actually be more concerning and likely warrant more immediate surgical intervention. Requested X is corresponding with patients subjective complaints and objective findings and is warranted. X is medically necessary and certified.
Overturned

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)**