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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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X stated X was at X. The mechanism of injury is described as X. The diagnosis was lumbar sprain / strain with radiculopathy. X, MD evaluated X on X for a follow-up on X. X reported pain radiating to the left lower extremity. It felt worse and was dull, sharp pain rated X. Constant walking made it worse. Numbness was new. X had been following the treatment plan, but it was not helping. X had been denied X. X had X, which had not helped X. MRI showed a X. Examination of the X. Flexion, extension, and rotation of the lumbosacral spine was decreased by X to X in all planes. X had a motor strength of X in the left lower extremity, X had a X on the left. Decreased X was seen in the X. X spasms were noted on the X. The assessment was lumbar sprain / strain with radiculopathy. Dr. X noted that X had been denied X. X would require an independent review organization to evaluate. An MRI of the lumbar spine dated X revealed at the X. Treatment to date included X. Per a utilization review adverse determination letter and a peer review dated X by X, DO, the request for X, on X to be performed on different dates of service was denied. Rationale: "The request is an appeal regarding a prior UR decision from X which denied X as the reviewer at that time noted. The records provided indicate that the patient is intended to receive an X. Based on the way the X are requested, it appears that the X. There is no mention of intent to engage in additional X. Updated medicals from X were submitted for review by Dr. X, M.D. ODG state that X. This treatment should be X. X are not recommended as a treatment for X. Criteria for X include well-documented radiculopathy with objective neurologic findings on physical examination. Patients should initially be unresponsive to exercise, physical methods, and medication. X are recommended to be X. In this case, the patient has a chronic injury. The most recent medicals indicate the patient presented with X sharp pain.

The patient has been following the treatment plan, but it is not helping. X has taken some X. X and a X helped a little bit. On exam, X. Lumbar MRI from X showed X. The plan indicates to appeal the denial of X under fluoroscopy with sedation on separate dates, X. The current requests are not medically necessary as there is no documentation of radiculopathy in specific dermatomal pattern documented by a physical examination that corroborates with specific pathology on MRI and no indication that this treatment is being administered in conjunction with active rehab efforts. There is lack of clarification if preop clearance is needed or if it was done. Therefore, the requested X is non-certified."Per a utilization review adverse determination letter dated X, the request for appeal X - not medically certified by physician advisor was denied by X, MD. Rationale: "Regarding the request for X. Not recommended for X or for nonspecific low back pain." "Patient criteria for X. A request for the procedure in a patient with chronic radiculopathy requires additional documentation of recent symptom worsening associated with deterioration of neurologic state. X. The patient has exam findings X. The patient has attempted X. The lumbar MRI reveals X at the requested levels. However, there is no rationale to perform this X. Given the patient's X. The overall documentation does not address a rationale as to why X. Therefore, the request is denied. "Thoroughly reviewed provided documentation including imaging interpretations and peer reviews. Patient with back pain radiating in to bilateral lower extremities consistent with lumbar radiculopathy. X failed X. Given continued pain, proceeding to X are warranted. Peer reviews took issue with potential plan for having X. X is unusual and it is unclear based on documentation provided if provider is actually attempting to do X. Regardless, per the guidelines cited by the 2 peer reviewers, the patient still meets criteria for X given presence of radicular pain and attempted prior first line treatment, along with corresponding imaging findings. X, on X to be performed on different dates of service is medically necessary and certified

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

Thoroughly reviewed provided documentation including imaging interpretations and peer reviews. Patient with back pain radiating into bilateral lower extremities consistent with lumbar radiculopathy. X failed X. Given continued pain, proceeding to X are warranted. Peer reviews took issue with potential plan for having X. X is unusual and it is unclear based on documentation provided if provider is actually attempting to do X. Regardless, per the guidelines cited by the 2 peer reviewers, the patient still meets criteria for X.X, on X to be performed on different dates of service 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)**