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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 at work on X while working for X. X was X. The diagnosis was lumbar sprain / strain. On X, X was evaluated by X, MD for a follow-up visit. X felt about the same as on the prior visit. X had X. X was able to do X. The pain was constant. There were no new symptoms. They had tried to get an X. X had undergone X. X had some type of X previously, which did not really help. MRIs had been performed. On examination, the BMI was 27.4 kg/m2. Examination of the lower back showed X. Flexion, extension, and rotation of the lumbosacral spine was decreased by X. The motor strength was X bilaterally in the lower extremities. X were noted in the X. The X was X. The assessment was lumbar sprain / strain. Dr. X noted they would appeal the denial of the X. X was trying to X. This had been denied because the review stated that because X was having X, X should not X. X wished to try conservative therapy before X. X also felt "X are in progress. "An MRI of the lumbar spine dated X revealed X. These findings could be seen with underlying X. Correlation with clinical symptoms was recommended. There were X. There was X. A X was seen. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for APPEAL X was denied. Rationale: "According to ODG, X is not recommended with radicular pain or anticipation of a surgical procedure. The provider is requesting authorization for a X are not recommended with radicular pain, spinal stenosis, previous fusion (same level), infection, tumor, coagulopathy, or anticipation of a surgical procedure. In this case, the patient was certified for X laminectomy and

decompression on X. The patient was noted to X. Given the fact that the patient's surgery is to treat X radicular symptoms, a X is not recommended. As a result, this request for a X is not supported by the guidelines. Therefore, my recommendation is to NON-CERTIFY the request for X Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for: X was denied. Rationale: "According to ODG, X is not recommended with radicular pain or anticipation of a surgical procedure. A peer review performed on X non-certified requests for X noting that the "provider is requesting authorization for a X. According to ODG, X are not recommended with radicular pain, spinal stenosis, previous fusion [same level), infection, tumor, coagulopathy, or anticipation of a surgical procedure. In this case, the patient was certified for X on X. The patient was noted to have X. Given the fact that the patient's surgery is to treat X radicular symptoms, a X is not recommended. As a result, this request for a X is not supported by the guidelines. In response, the provider notes that the patient is reluctant to get X. While the provider's response is acknowledged, the patient is noted to have lumbar radiculopathy. X are not recommended for chronic radicular pain syndromes. Additionally, current evidence-based guidelines do not recommend use of X, diagnostically or therapeutically. X are not recommended based on insufficient evidence for support. Diagnostic X are not recommended as there is no further definitive treatment that can be recommended based on any diagnostic information potentially rendered. Consideration may be given on a case-by-case basis for X. However, the medical records for this patient do not provide objective evidence (i.e. imaging, labs) of X, typically a diagnosis based upon a rheumatological origin. For these reasons, this request for a X is also not medically substantiated. Therefore, my recommendation is to NON-CERTIFY the request for APPEAL:X The requested X are not medically necessary. The guidelines do not support X. In addition, the request is also for X. The guidelines do not support the use of X. There is no rationale as to why X is necessary for these X. In addition, the MRI

report does not demonstrate any evidence of X. Currently, the patient also reports radicular symptoms on the right leg whereby X are not indicated. Thus, the guidelines have not been met for multiple reasons. No new information has been provided which would overturn the previous denials. 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 are not medically necessary. The guidelines do not support X. In addition, the request is also for X. The guidelines do not support the use of X. There is no rationale as to why X. In addition, the MRI report does not demonstrate any evidence of X. Currently, the patient also reports radicular symptoms on the right leg whereby X are not indicated. Thus, the guidelines have not been met for multiple reasons. No new information has been provided which would overturn the previous denials. 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