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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 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 was working as a X who was injured at work on X when

X was X. The diagnosis was lumbago with sciatica on right side and lumbago with sciatica on the left side. On X, X was seen by X, MD for continuing pain and stiffness in X. X had X done in X followed by X in X. X had also been participating in X. X said the treatments had given X relief, but X continued to experience X. X said that X was also experiencing frequent X. X described X pain level as X on the X. X was a X. Back examination revealed X. X in lumbar spine was X. X test produced only back pain. X test produced centralized low back pain. Lower extremity neurological examination was unremarkable with X reflexes at X knees and X reflexes in X. X was intact. X examination was normally X. At that visit, X complained of X. On assessment, there was X. X symptoms appeared to be related to X. X was recommended continuation of those exercises, otherwise. X had an excellent response to the X. On X, X was evaluated by X, PT. The X scoring was X. X rated pain X at worst and X as pre-treatment. The work status included X was not working since X. On assessment, X had completed X visits of X. X stated that X. X job required for X. X were limited by pain. X also reported that X ability to X. Utilizing X report of how long X could X because X came for X. At that time, X . X stopped secondary to X. X was attempting to maximize X. Thus fur, X had not able to increase X. X subjective report on X. X was recommended X in an attempt to increase work category, as well as. X. An MRI of the lumbar spine dated X revealed X changes were present. This appeared most pronounced at least moderate in severity on the right side at X. There was X. Marked X was present on the right at X including the presence of a X. Less pronounced X was noted bilaterally at X , the left at X and bilaterally at X. There was also X present on the right at X. X of the exiting right X nerve root was present. There was X seen on the left at X. There was X on the right at X, on the left at X and bilaterally at X. There was X seen. There was X seen. An MRI of the X dated X revealed X. X were intact. There was no evidence of X. There was no evidence of X present. X was X. There was X. There were X. An MRI of X dated X, revealed X. There was no evidence of X. Mild left X was noted. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “ODG guidelines note Recommended as indicated below. There is strong evidence that X. Lumbago; Backache, unspecified: X visits over X weeks. The patient has completed X sessions of X for X noted. This request exceeds guideline recommendations and there is insufficient documented objective evidence of derived functional improvement with the therapy that has been completed. Also, the maximum number of X sessions recommended by the

guidelines has been met. There is no documentation to further exceed guideline recommendations over transitioning into a home exercise program. Based on the records reviewed, the medical necessity for this request has not been established, and therefore, the request is non-certified." Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the appeal request for X was upheld. Rationale: "The requested X is not medically necessary. The records reflect that the patient has already attended X. No records have been submitted from the provider which would indicate the rationale for X. The guidelines do not support X. Therefore, the appeal request for X is upheld and non-certified." The ODG recommends up to X visits of X for the treatment of X and X visits for low back pain. The documentation provided indicates that the injured worker reports low back pain and left hip pain. They previously underwent X of the lumbar spine. They have also been participating in X. They report tingling in the left leg. On exam they have limited motion of the lumbar spine, back pain with X raise, and an unremarkable neurologic exam. They previously attended X visits of X. There is a current request for X. When noting that guidelines have been exceeded and there is no indication of home exercises could not be utilized, X is not supported. As such, 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 ODG recommends up to X. The documentation provided indicates that the injured worker reports low back pain and left X pain. They previously underwent X of the lumbar spine. They have also been participating in X. They report X in the left leg. On exam they have X of the lumbar spine, back pain with X, and an unremarkable neurologic exam. They previously attended X. There is a current request for X. When noting that guidelines have been exceeded and there is no indication of home exercises could not be utilized, X is not supported. As such, 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