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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who sustained an industrial injury on X and is seeking authorization for a X. A review of the medical records indicates that the injured worker is undergoing treatment for X.

Previous treatment has included X.

Previous X on X.

The X progress report has the injured worker with lower back pain. X is status post previous X on X. X reports the symptoms are unchanged since the last visit. X denies having any X. The low back pain radiates to the left buttock and down the back of the left leg stopping above the knee. The pain score is X. Overall, X back hurts after X. The exam reveals an X. There is a X. There is X. There is also X. X are all X. The strength is X. X is diminished on the X. X and sitting X. X has abdominal pain located X. The treatment plan included proceeding with a X.

The X progress report has the injured worker seen in follow-up from the X on X. X reports overall feeling different after X. The pain scale today is X. X has low back pain that is worse to the X. X back hurts to X. The pain continues to radiate down the lateral and posterior left leg, bilateral buttocks, and back of the upper right leg. The exam reveals an X. There is a painful X. There is X. There is also X. X are all X. The strength is X. X are positive on the left bilaterally. The treatment plan included a repeat X.

The X progress report has the injured worker with low back pain and lumbar radiculopathy. X underwent surgery or most recently X in X. The pain continues to be described as X. Overall symptoms have changed since the last visit. The

pain is rated at X. X lower back hurts and overall feels left X. Height is 73 inches, weight is 237 pounds, and body mass index is 31.3 kg/m². The exam reveals a X. There is X. There is also X. X are all X. The strength is diminished in the X. X is diminished on the X. X are positive on the X. The treatment plan included a X.

The X Utilization Review report cites current evidence-based guidelines and notes that the requested procedure is not recommended. Clarification is needed regarding what procedure was performed on X (as the most recent office visit note provided indications that the patient underwent a X on X and an X.) The claimant reports X relief following the procedure on X for a few weeks. There are no serial VAS scores provided. There is no documentation of increased functionality or decreased medication usage. Therefore, the medical necessity is not established in accordance with current evidence-based guidelines.

The X Utilization Review report cites the records noted the patient received a X, with reports of X pain relief for a few weeks. The physician was recommending a X. However, given that the patient received a X. The physician would typically need to address this issue before authorization can be given for a X. Furthermore, if the patient truly received significant benefit from the X, it was unclear why the physician would not proceed with more definitive treatment for this condition. The case was discussed with "X" who stated the patient's pain level was X prior to the X and was reduced to X after the X. However, the issue regarding the patient receiving a X was not addressed. Until such time as information is received to verify that the pain relief was attributed to the X. As such, in accordance with the previous denial, the appeal request for X is non-certified.

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

As per ODG, “Not recommended, including X. X are not recommended (a change as of X) as there is no further definitive treatment that can be recommended based on any diagnostic information potentially rendered (as X are not recommended for non-inflammatory pathology). Not recommended: X.”

Also, as per ODG, “Not recommended X. This is a condition that is generally considered X. Instead of X is recommended. Current research is minimal in terms of trials of any sort that support the use of X. Below are current reviews on the topic and articles cited. There is some evidence of success of treatment with X.”

In this case, this X sustained an industrial injury on X, is seeking authorization for a X.

Overall, X presented on X with low back pain and lumbar radiculopathy. X underwent surgery or most recently X in X. The pain continues to feel like X. Overall symptoms have changed since the last visit. The pain is rated at X. X lower back hurts and overall feels X. Height is 73 inches, weight is 237 pounds, and body mass index is 31.3 kg/m². The exam reveals a X. There is X. There is also X. X are all X. The X is diminished in the X. X is diminished on the X. X are X.

However, detailed documentation is not evident regarding imaging or radiographic evidence supporting a diagnosis of inflammatory sacroiliitis. There is no clear failure of conservative treatment directed to the X. Moreover, the ODG guidelines do not recommend X. No compelling rationale is presented, or extenuating circumstances noted to support

the medical necessity of this request as an exception to guidelines. Therefore, the request for X is not medically reasonable or necessary.

**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 JUDGEMENT, CLINICAL
EXPERIENCE AND EXPERTISE IN ACCORDANCE
WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE
GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES &
TREATMENT GUIDELINES**
- PRESSLEY 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)**